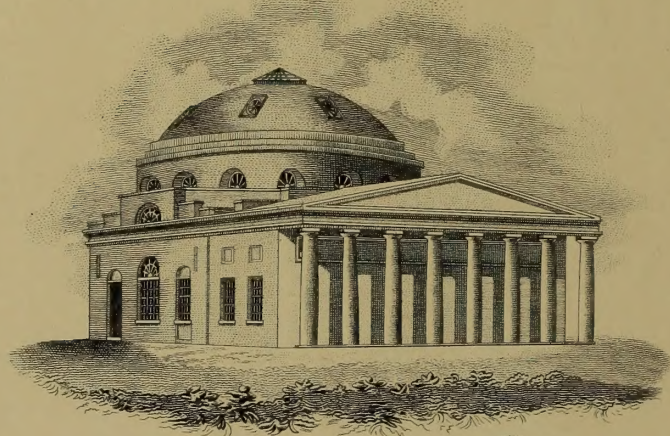


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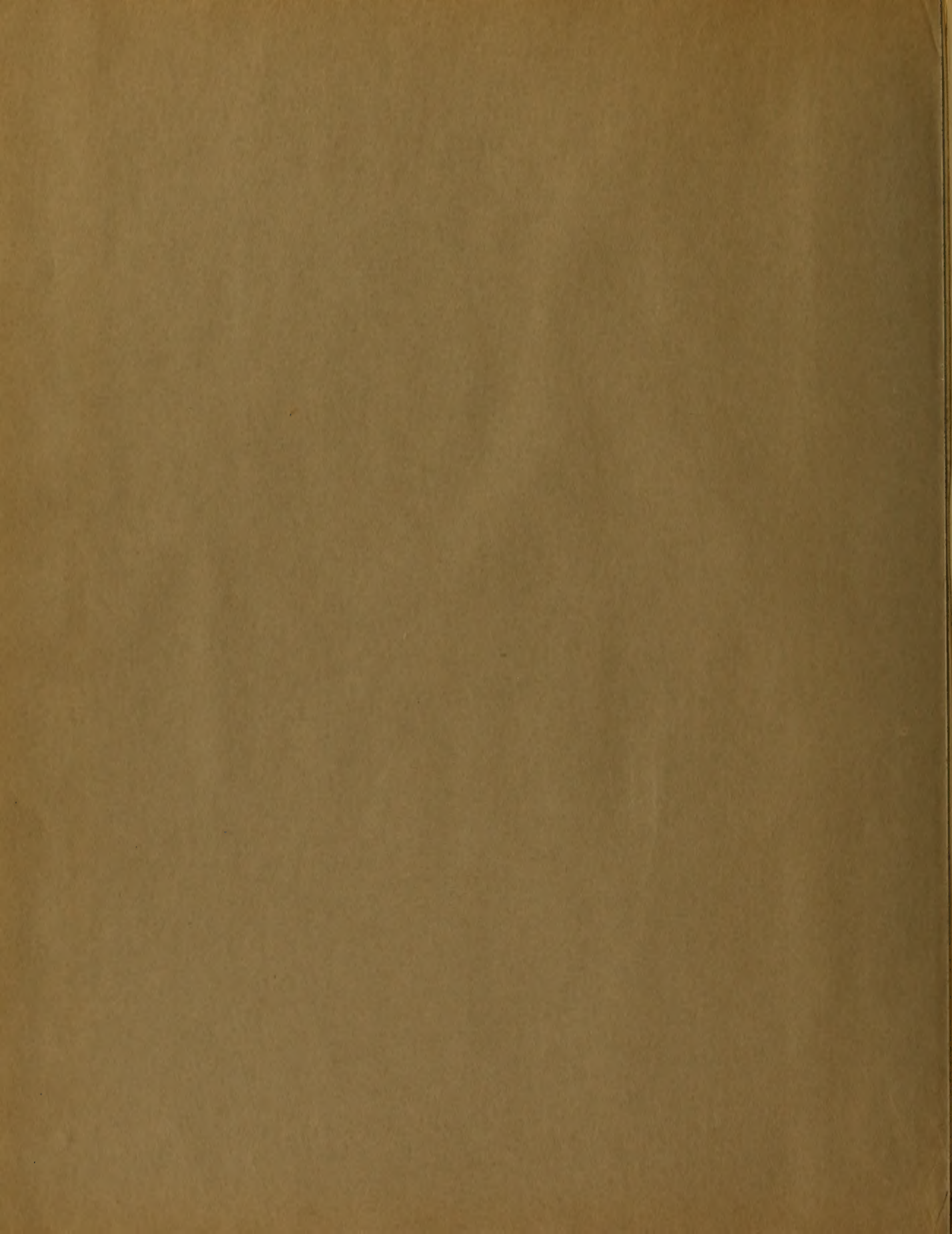
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University of Maryland Theses

Early Doctor of Medicine and Doctor of Physic Dissertations with Corrected Tables of Contents

These manuscripts described as either an Inaugural Dissertation or an Inaugural Essay were presented to the University of Maryland for the Degree of Doctor of Medicine and/or Doctor of Physic during the years 1813-1887. The individual dissertations were bound together during the 1940's. The original tables of contents for the bound volumes contained multiple errors in authors' names, titles, and/or years. To address these errors, an additional "Corrected Table of Contents" has been inserted at the beginning of each volume.

The project team who investigated and corrected the tables of contents were Richard J. Behles, Historical Librarian/Preservation Officer; María Milagros Pinkas, Metadata Management Librarian; Angela Cochrane and Carol Harling-Henry, Resources Division; Sarah Hovde, Abra Schnur and Megan Wolff, Services Division.

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(CORRECTED TABLE OF CONTENTS)

UNIVERSITY OF MARYLAND

THESES

1877 (c)

Author	Title	Notes
Hopkins, D. W.	Report of Six Cases	
Butter, John B.	Acute Croupous Pneumonia	
Gordon, L. Charles	Diphtheria	
Laws, Cassius D.	Pneumonia	
Sigler, George P.	Hygiene	
Hargrove, R. H.	Cirrhosis of the Liver	
Sledge, James T.	Diphtheria	
Ellis, Robert H.	Cholera Infantum	
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Irwin, J. Robinson	Hypertrophy of the Heart	
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Andrews, George W.	Diphtheria	
Briel, Frederick	Iritis	
Doerner, John A.	Report of Six Cases	
McCormick, Thomas P.	Digestion and its Derangements	

Author	Title	Notes
Author Unknown	Amputation of the Forearm	(No title page)
Whiteside, B. Frank	Acute Croupal Pneumonitis	
Hunley, Luther B.	Pneumonia	
Jacobs, James K. H.	Croup	(Text lost in binding)

UNIVERSITY OF MARYLAND

THESES

1877 (c)

Hopkins, D. W.	Report of Six Cases	27p.
Butter, ^{John} J. B.	Acute Croupous Pneumonia	20p.
Gordon, ^{Charles} L. S.	Diphtheria	24p.
Laws, ^{Cassius} E. D.	Pneumonia	20p.
Sigler, ^{George} G. P.	Hygiene	16p.
Hargrave, ^o R. H.	Cirrhosis of the Liver	21p.
Sledge, ^{James} J. T.	Diphtheria	24p.
Ellis, ^{Robert} R. H.	Cholera Infantum (1)	20p.
Van Bibber, Claude	Gun-Shot Wounds of the Abdomen (2)	41p.
Irwin, ^{Robinson} J. R.	Hypertrophy of the Heart	23p.
Harvey, G. B.	Typhoid Fever	24p.
Shubrick, ^{Templar} J. T.	Ovariectomy	17p.
Andrews, ^{George} G. W.	Diphtheria	20p.
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McCormick, ^{Thomas} T. P.	Digestion and Its Derangements	40p.
^{Author Unknown} Anonymous	Amputation of the Forearm	10p. No title page
Whiteside, ^{Frank} B. F.	Acute Croupal Pneumonitis	13p.
Hunley, ^{Luther} L. B.	Pneumonia	27p.
Jacobs, ^{James} J. K. H.	Croup (3)	31p.

(1) Long pages, all folded at bottom

(2) Pages out of order

(3) Some text of thesis lost in inner margin during binding process

Handwritten text in the left margin, possibly a list or index.

Main body of handwritten text, appearing to be a list or index of items.

Handwritten text in the right margin, possibly a list or index.

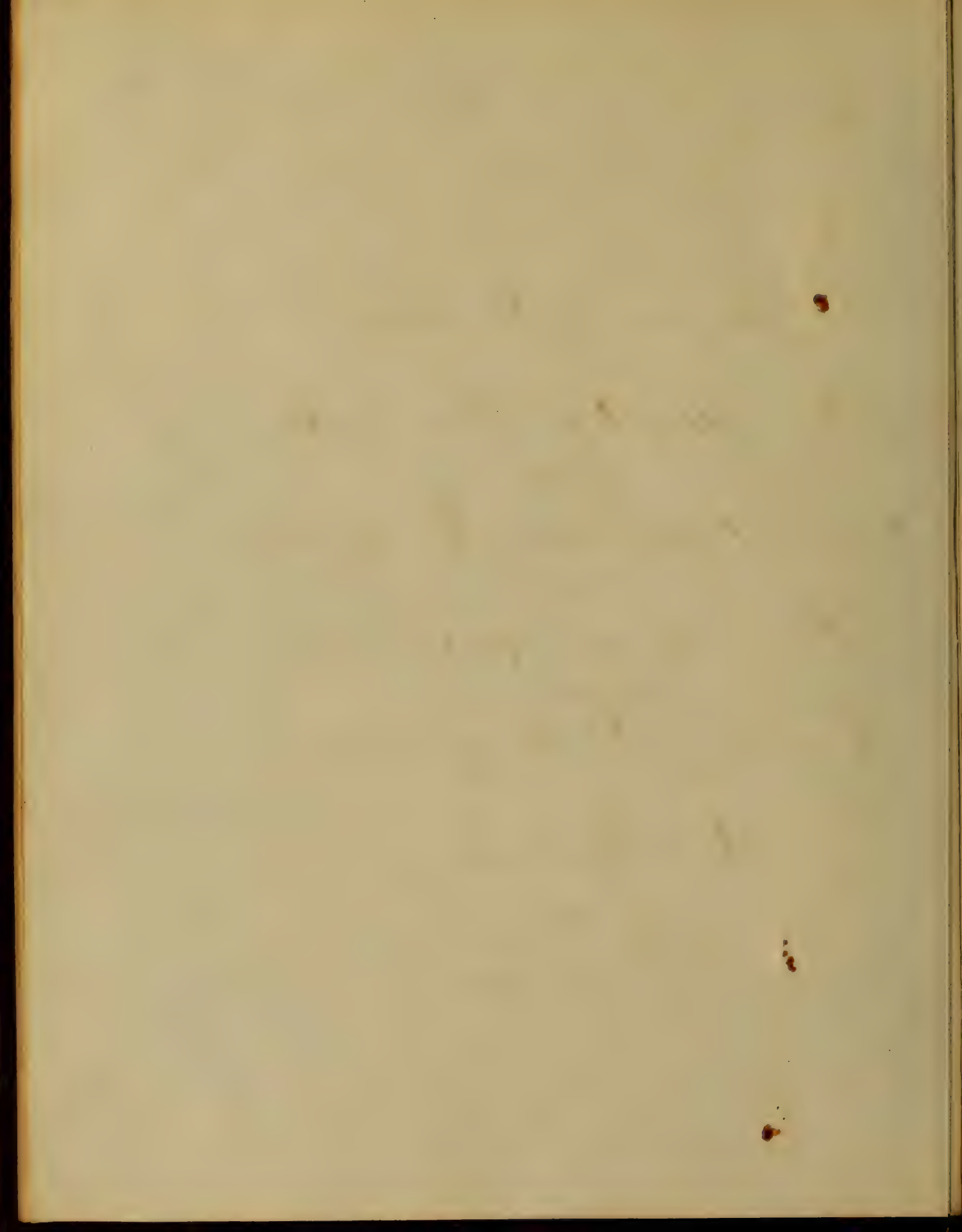
A Report of Six Cases.

Submitted to the Examination
of the
Sewall Regents and Faculty of Physic
of the
University of Maryland.
for the
Degree of Doctor of Medicine
by
D. W. Hopkins
of the
Class of 1877.

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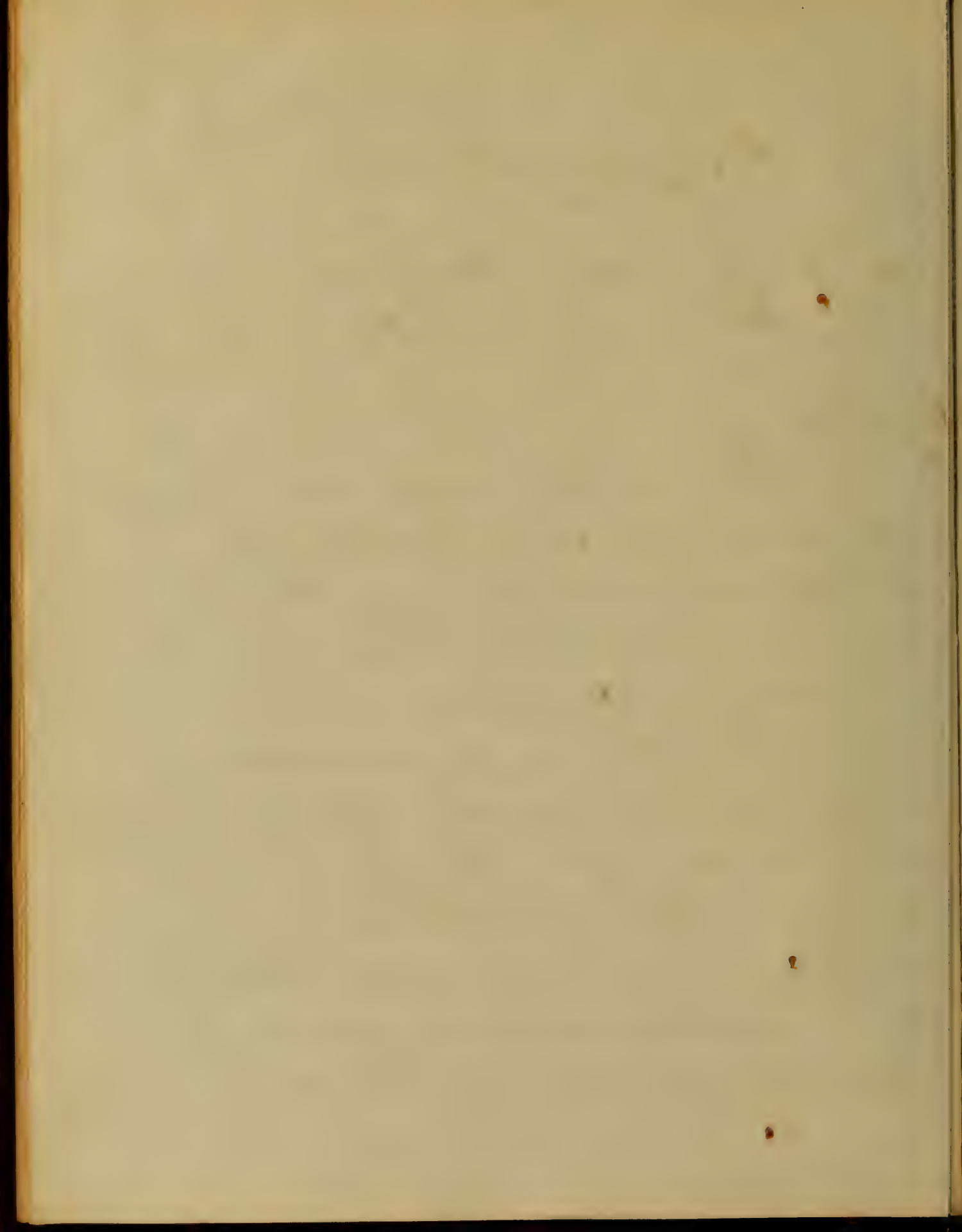
1

A Report of Six Cases

No. 1. John King - Coast Occupation,
Farmer - Height - $5\frac{1}{2}$ - Age 42

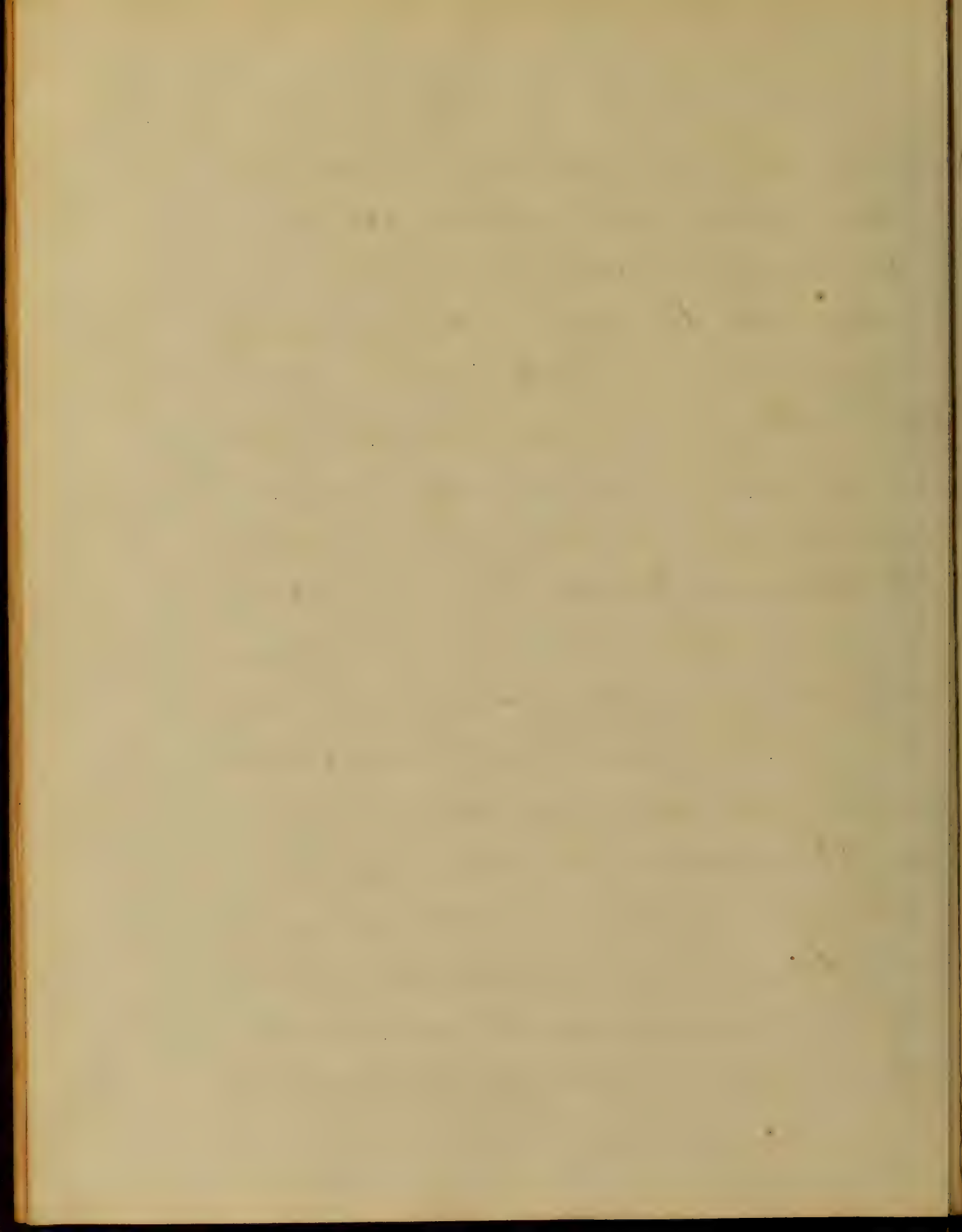
Apr 6th / 6.

This man has been sick since
Christmas, when the cough and shortness
of breath came on, and swelling of his lower
limbs occurred. Shortness of breath especial-
ly on going up stairs. Bowels have been
regular. Since this evening one hundred
Dyspnoea increased after coughing.
Complaints of no pain. Temperature nine-
ty eight and three fifths. Near the spine
little respiratory murmur could be heard.
On the right side dullness on percussion,
extending from the fourth rib downwards



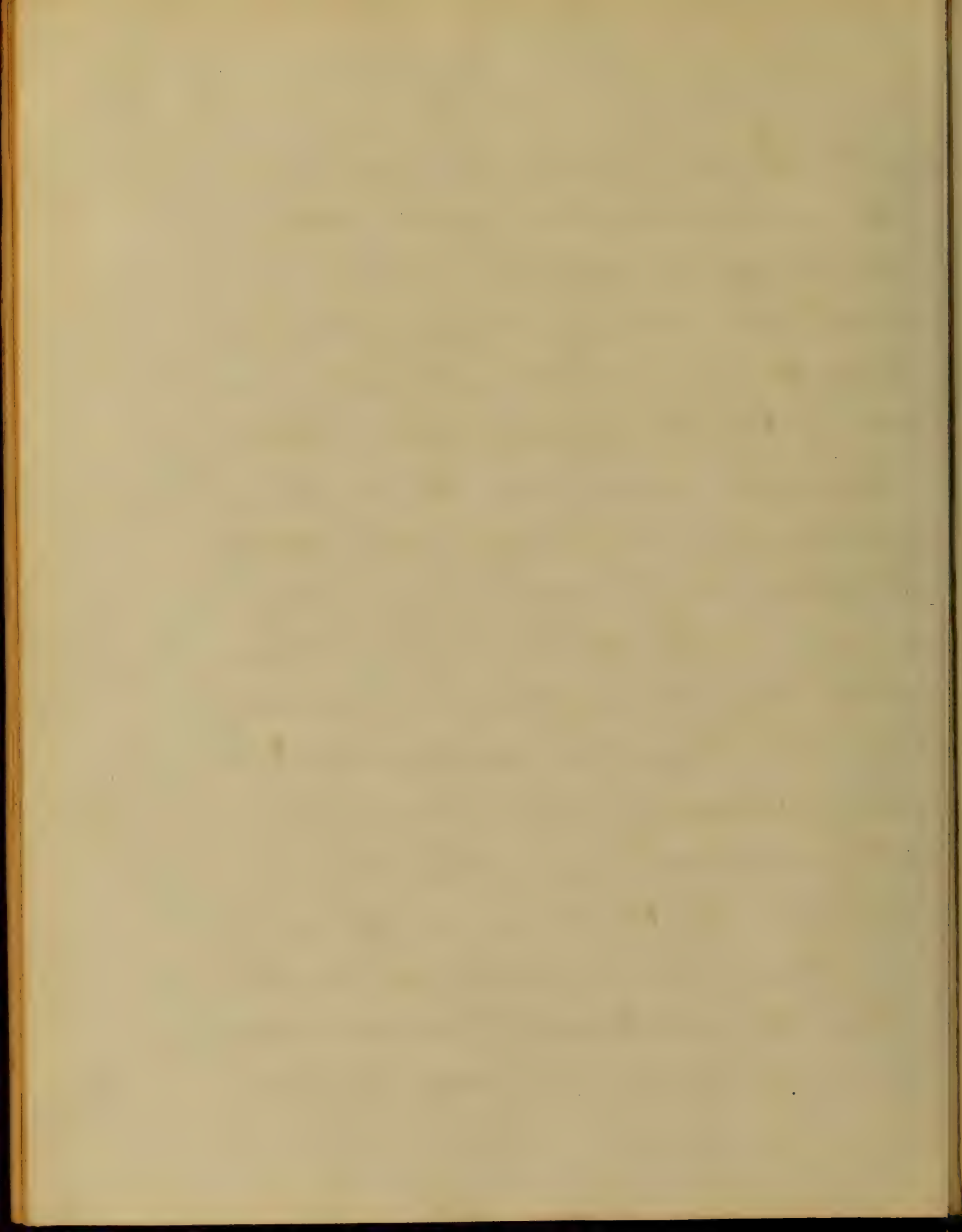
Absence of vesicular murmur and bronchial respiration. On measuring the chest there was found the difference of one inch between the two sides. nineteen inches on the right side and eighteen on the left side.

Apr 7th This morning the aspirator was used, and eighty fluid ounces of fluid were drawn off which was serous in character. About this time the patient began to suffer from pain in his chest and coughing, then the needle was withdrawn leaving an unknown quantity of fluid in the chest which was afterwards drawn off by Prof' Donaldson. This evening he feels better since fluid was extracted, no pain excepting when he coughs, and this he does not do so much since he was aspirated, Breathing easier, and Appetite good.



13

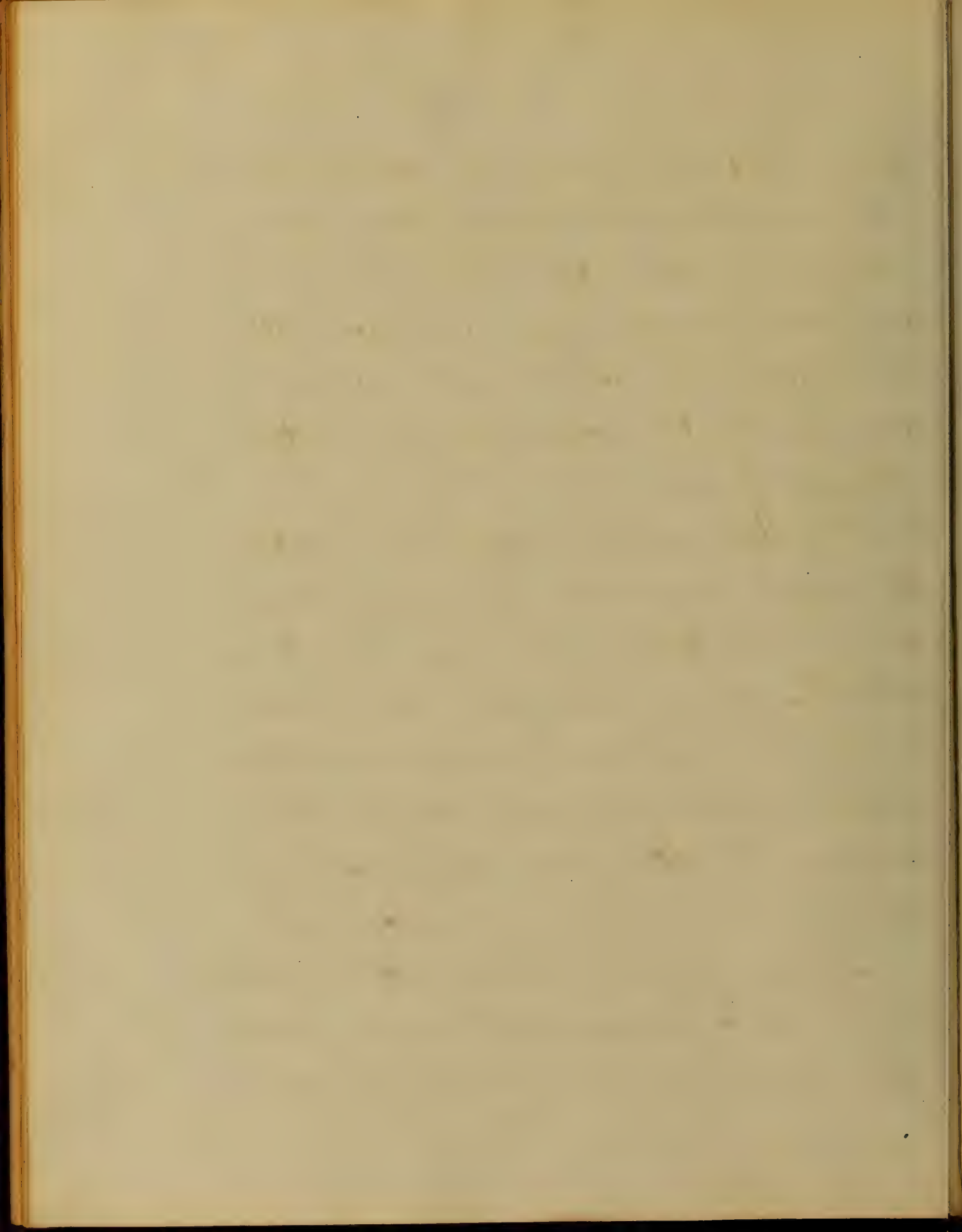
Sept. 8th Today I find him considerably improved: having taken elaterium in half grain dose, and his shortness of breath also his pain relieved, Appetite good. One action from his bowels, Pulse one hundred. Sept 9th Coughed a great deal last night which prevented his sleeping, consequently not feeling any the better for it. Shortness of breath increased by coughing. Expectoration difficult - Complaint of pain in his head and swelling of his limbs. He is unable to lie down. Passage from his bowels small. This evening we find him no easier, but fair, the troublesome cough and his soreness in his abdomen increased, Appetite not altered. Expectoration kind, of frothy. Exercise increases shortness



27

of breath Pulse ninety six and his bow-
els somewhat constipated. Had a slight
action from them this morning. Swell-
ing still continues. Respiration thirty two
So we gave him three compound cathar-
tic pills, to take and Brown mixture
to quiet cough.

Apr^{10th}. This morning we find his symptoms
the same and action from his medicine.
Brown mixture continued. This afternoon
Prof Donaldson made an examination
and discovered complications, systolic
murmur caused by insufficiency of mitral
orifice. - Friction sound, and dullness
on percussion. The former on the right-
side and the latter on the left side one
inch below the angle of the scapula. No in-
flammatory action on the left side;

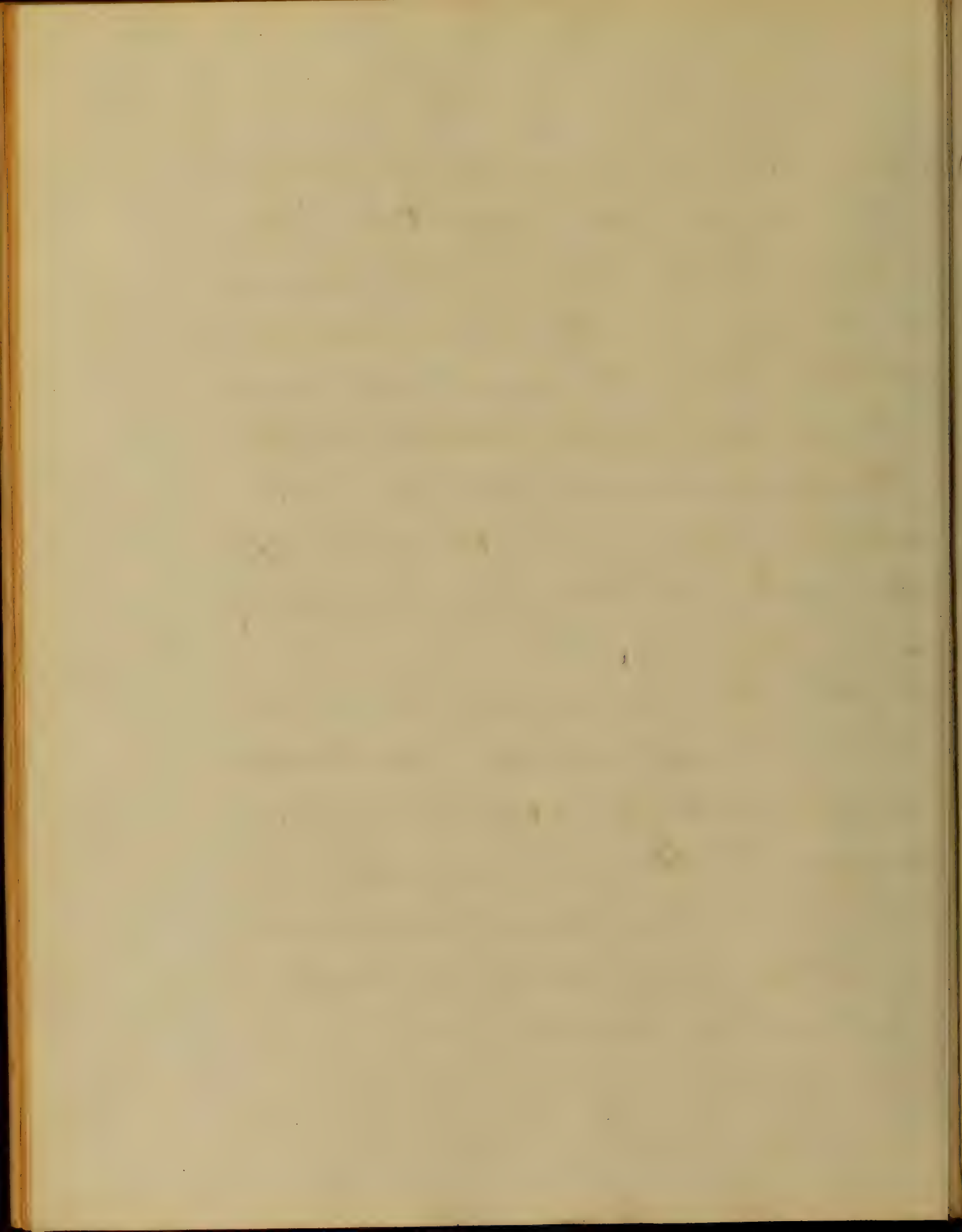


dullness being caused by passage of fluid from the right to the left side.

There is absence of vesicular murmur on the right side. This evening at six o'clock he felt better every way; pulse one hundred. Respiration thirty six. His treatment consists of the Syrup of the Iodide of Iron in thirty drop doses three times during the day, along with one half ounce of whisky.

Apr 11th. This his sixth day I find none the better; but slept well during the night. Breaths acted, and appetite remains unimpaired. At six this evening there is no change, but complains of pain in his joints, and palpitation of his heart.

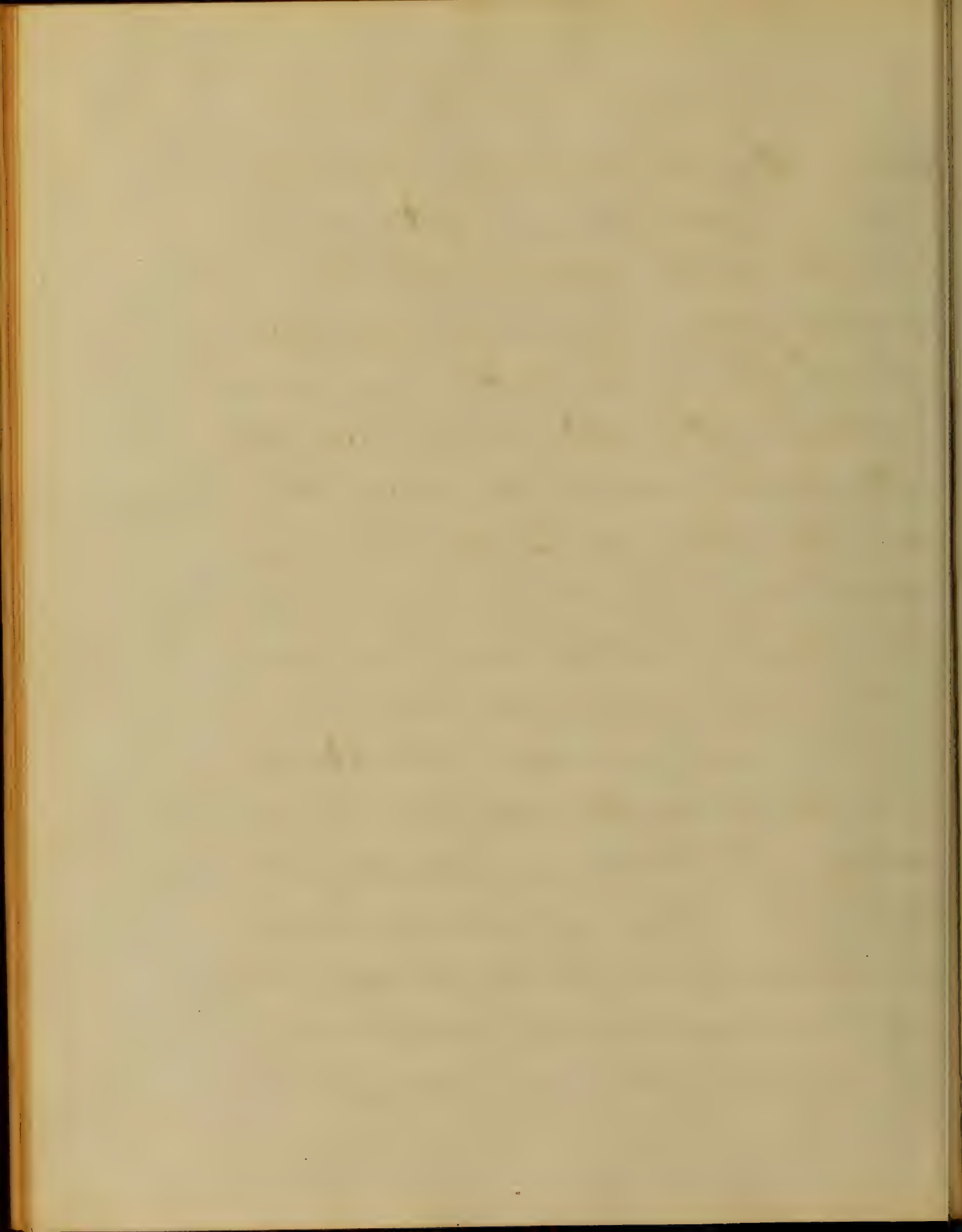
Treatment the same,



6.

Apr. 12th. Unfortunately we found little more
the better after this mode of treatment,
Dr Ashby having ordered the staterium
in half grain doses and Syrup of the
iodide of Iron with the usual amount
of whiskey to be continued. In fact this plan
of treatment was continued until Apr
the 14th with no decided improvement and
on this day Dr Donaldson examined Lizzy
and says she has slight bronchitis and may
have effusion of pericardium.

Nothing more was done than to admin-
ister Ammonia Carb. every three hours
along with the other remedies. He contin-
ued this manner of treatment until the
seventeenth when Dr Donaldson called and
after an examination, used the aspirator
for the second time and drew off serosity



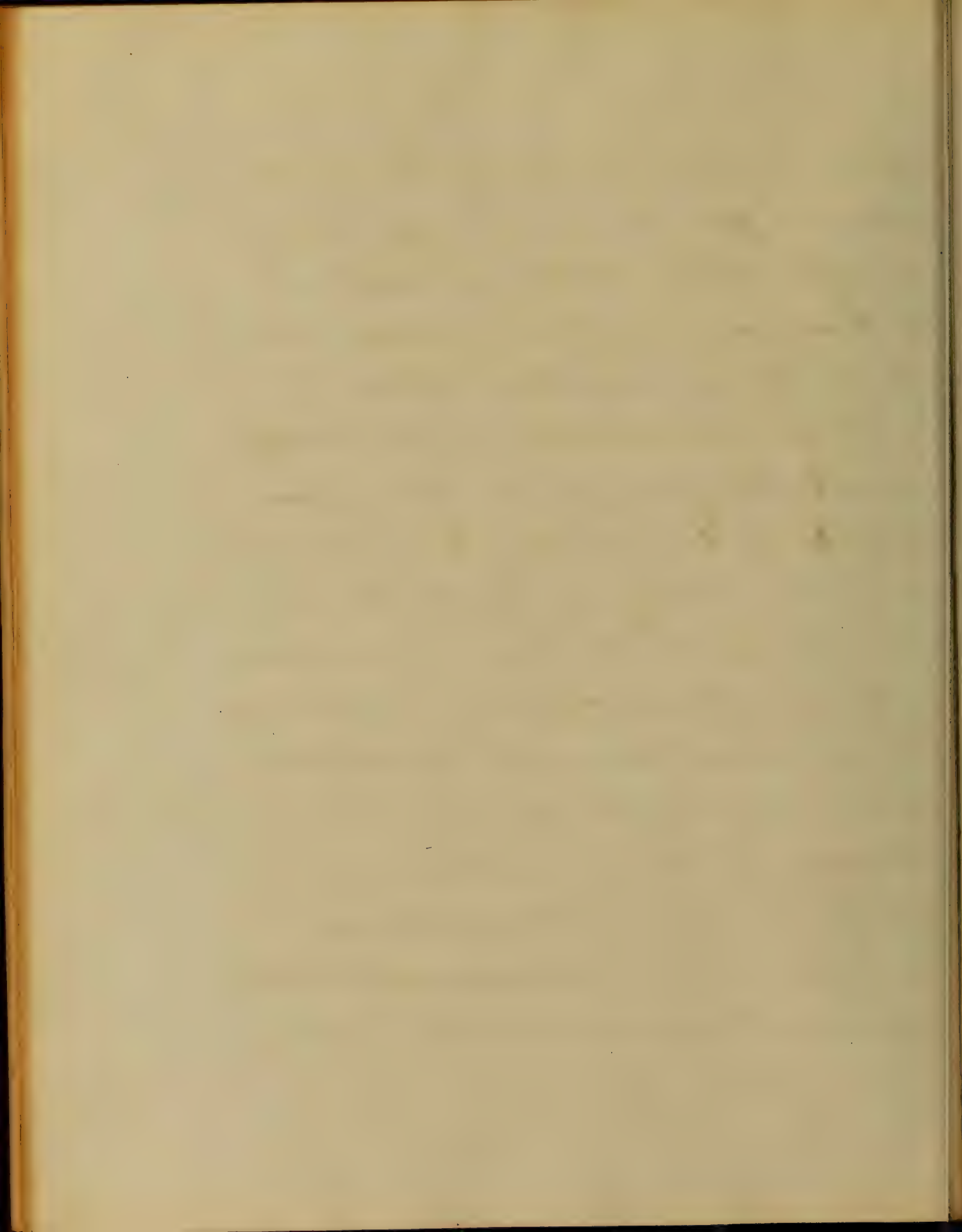
fluid of serous fluid. There was dullness on percussion on the right side before operation. As soon as the instrument was introduced cough became much easier and stopped to a certain extent.

After all this attention no decided improvement took place, and all that remained was to continue the said treatment, which was done faithfully by the Ward master.

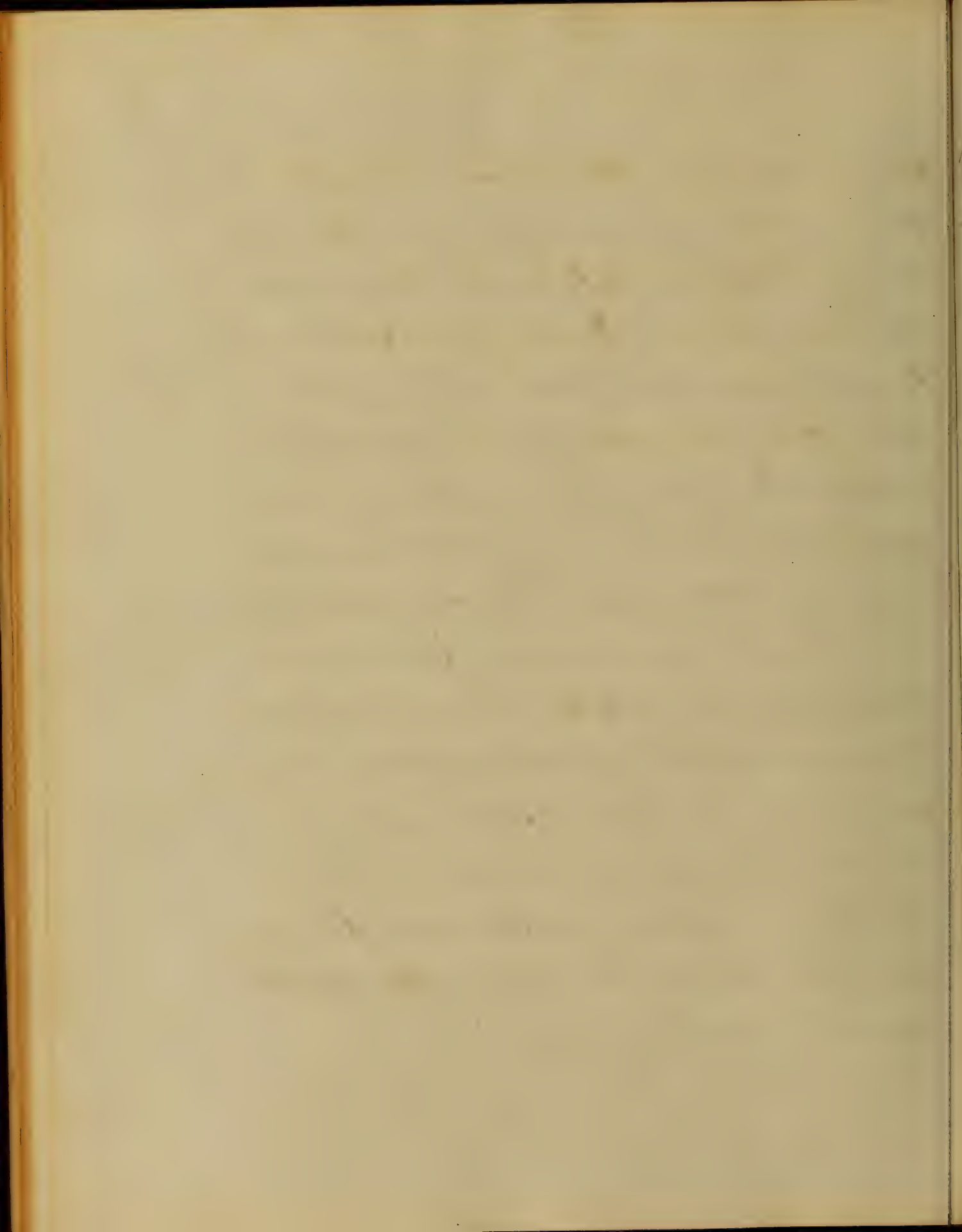
He breathed his last at seven o'clock, A.M. 19th after an illness of twelve days.

What is remarkable about this man's case, is, that his appetite did not fail him throughout his whole illness.

Apr 19th Death from Subacute Pleurisy, complicated with thickening of the mitral valve of the heart. Result of Post Morteum,

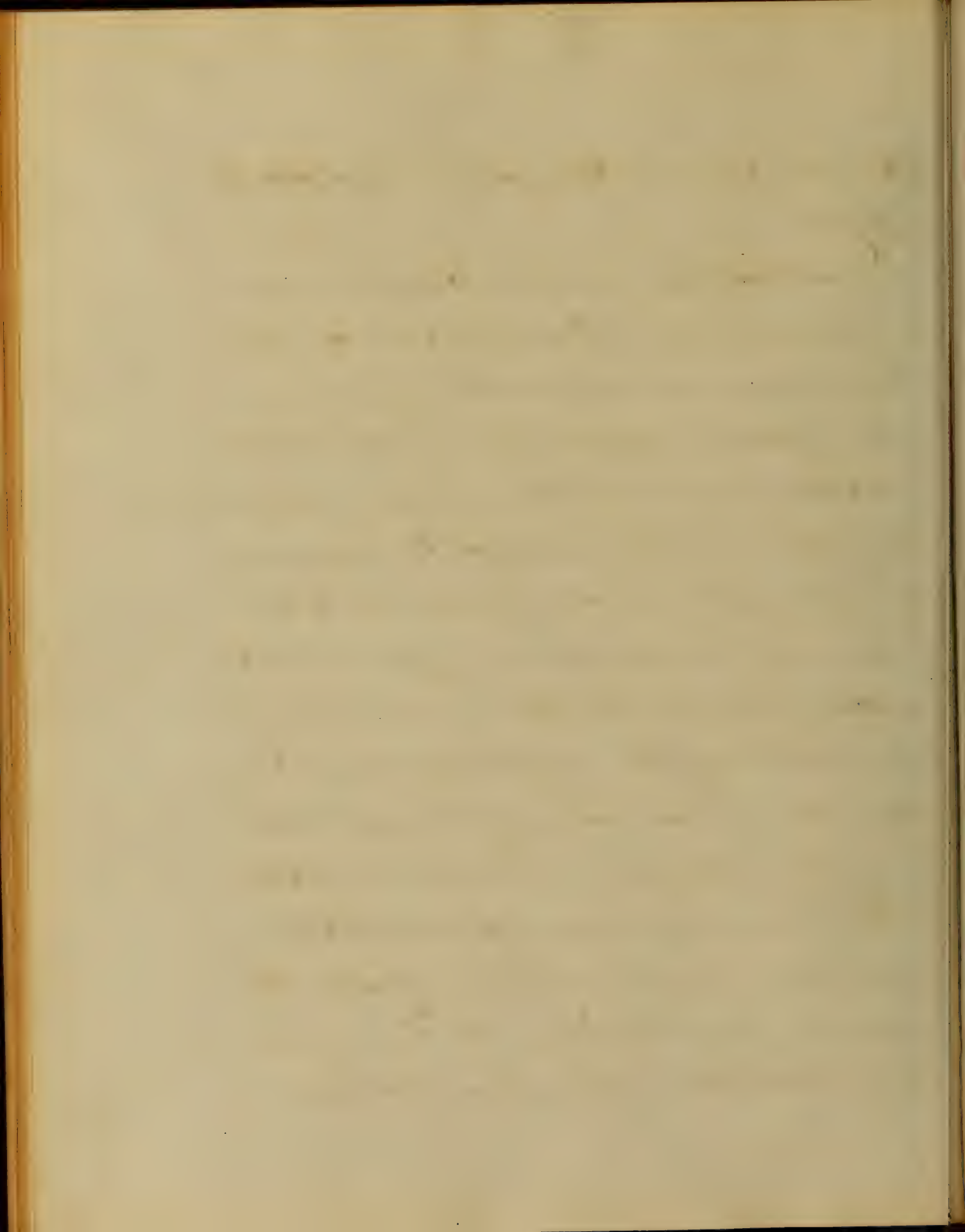


Pleural cavity contained a considerable
 amount of effusion, especially on the right
 side. The upper portion was clear, but near
 the bottom it was turbid from the admis-
 sion of coagulated fibrin or lymph which
 is the characteristic product of inflam-
 mation. Deposit of fibrin in the left ventricle
 of the heart, Thickening of the mitral valve,
 sufficient to account for the death, togeth-
 er with the subacute Auricle. There was a
 slight perforation of the Tricuspid valves.
 No deposit in the lung but a calcareous de-
 generation, the effect of the subacute bron-
 chitis, Kidneys and Liver normal.
 Dropsical effusion into the areolar tissue
 over his lower extremities, also into the
 scrotum and penis.

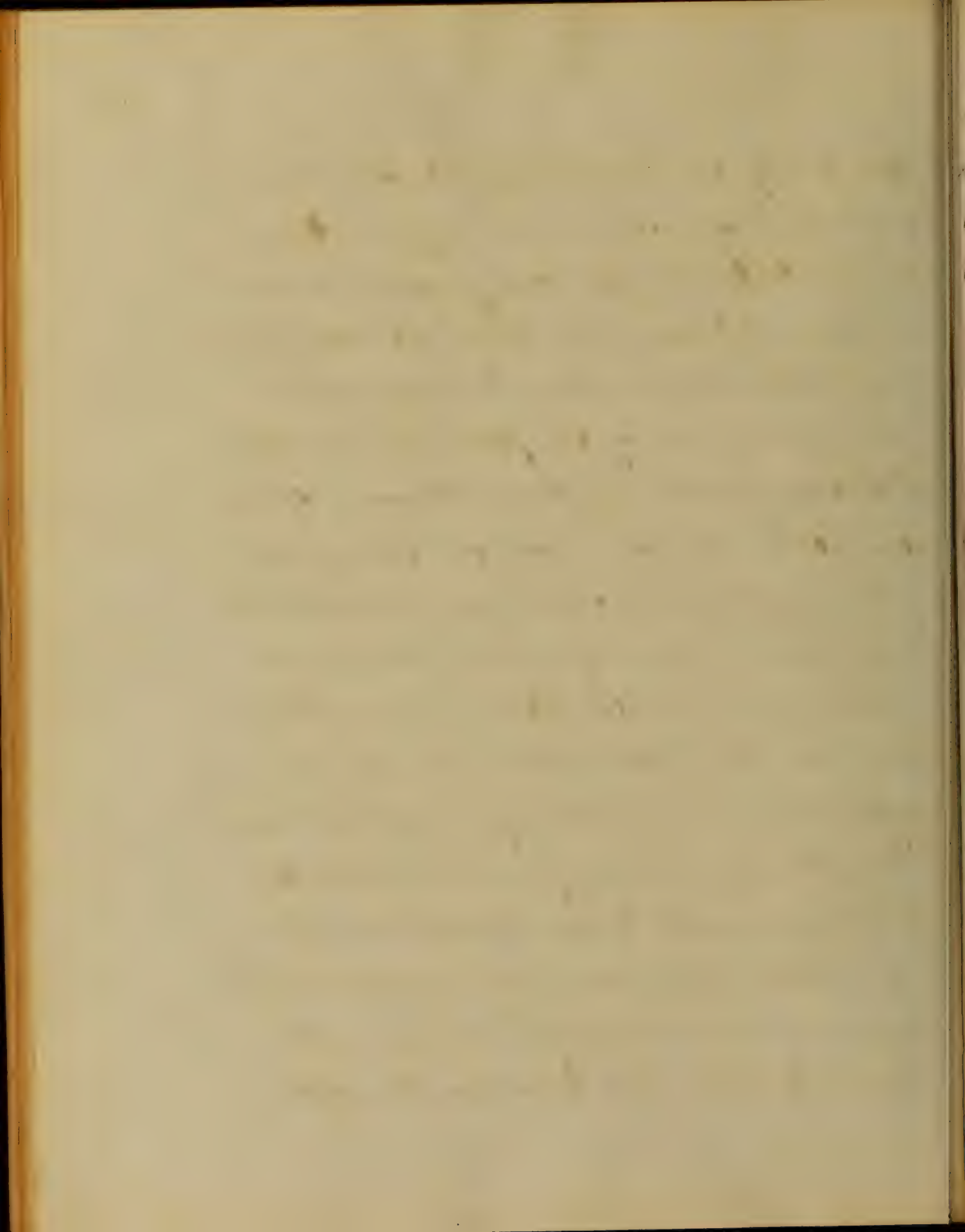


No. 11. John Brown - Occupation - Clerk, age 23,
Sept 23rd

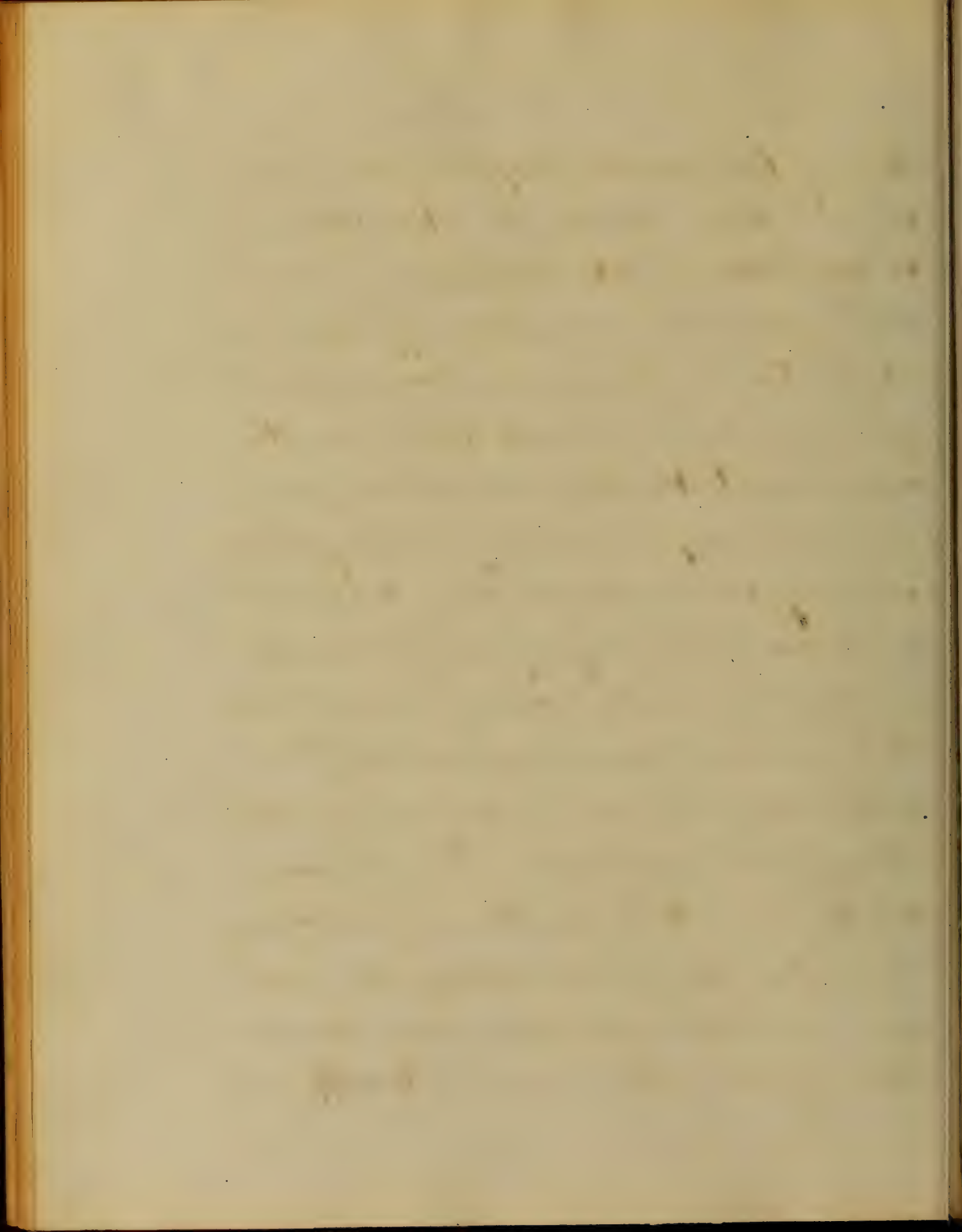
During my sojourn at home this summer I was called upon to visit a young man laboring under intermittent fever, commonly called ague by those who inhabit malarious districts and are frequent sufferers of this malady. On my arrival I inquired of the young man as to the cause of his ailment, and found that two days previous he had remained out a portion of the night in a rain storm, and the remainder of the night he sat up by a hot fire with his wet clothes. The following evening he was taken with the usual symptoms of ague if may be permitted to use the term for brevity - First the chill, secondly the fever



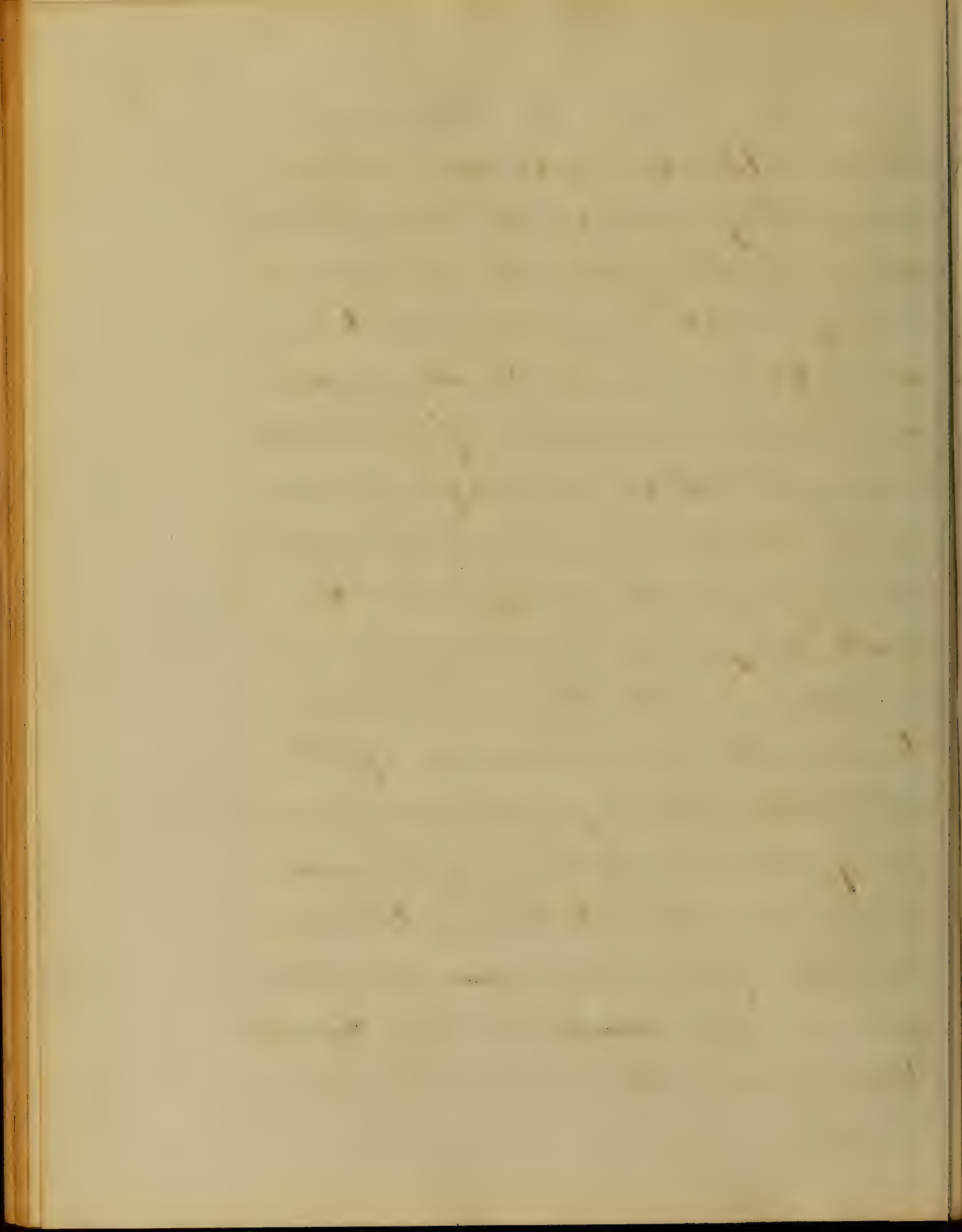
and chiefly the sweating, after these have subsided and intermission from twelve hours to twenty four and frequently much longer, After the first attack passed off his pulse was administered some purgative pills composed of the following ingredients *℞ Colocynth comp gr̄v̄, Colmel, gr̄s̄ iij̄ and Rhei gr̄s̄ iij̄* made into three pills following these in the morning with a Sudorific powder. A slight operation followed the medicine, In the afternoon he was taken with a chill after that a high fever during which he was partially out of his mind, This having passed off in an hour or two I administered *Colmel gr̄s̄ viij̄* and six hours later half ounce of *magnesia sulph* which produced a copious evacuation The next thing was to pour in one of the



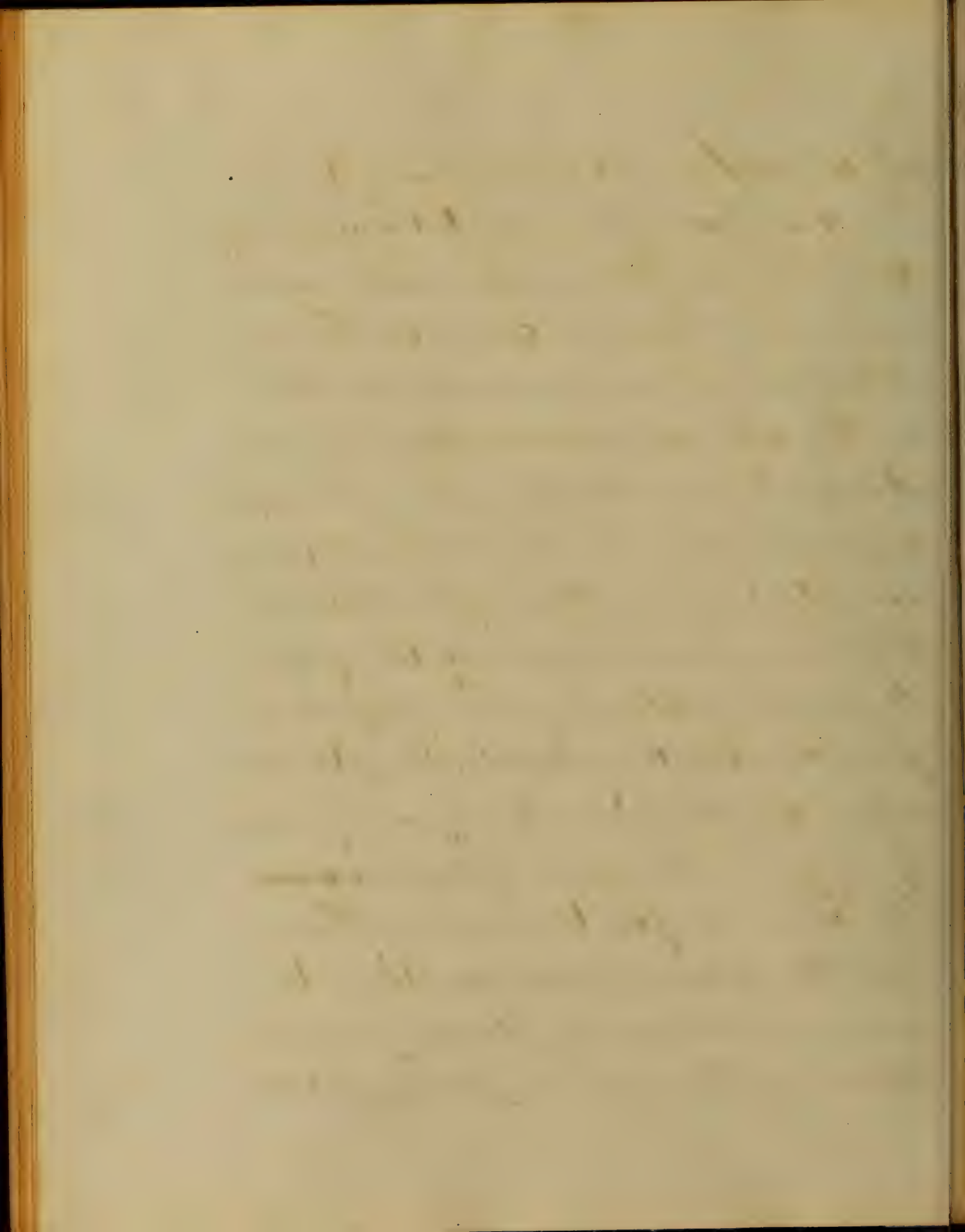
Salts of Quinia the Sulphate was used
in five grain doses four times during
the day. Called next morning, and found
that a chill had just passed off, and was
at the time suffering with a very high
fever, not possessing a thermometer
was unable to take temperature. At any rate
I immediately suspected brain-floy, that is,
that my quinia had not been looked but
could not make myself satisfied on that
point, while there I ordered mustard plasters
to his wrists ankles and back of his
neck, which in a few minutes relieved
him from great pain. Then I ordered
the Quinia to be continued, first giving
him ten grs immediately after parox
ysm and then five grain doses at inter-
vals of four hours until twenty grains



had been taken during the day, which
 completely broke up the chill. The inter-
 nal use of chloroform has been recommen-
 ded by Dr A. P. Merrill a practitioner
 of New York. Given in ʒi doses either
 alone, followed immediately by cold water
 or suspended in mucilage has been
 found to arrest progress of chill and
 induce refreshing sleep, which the
 patient enjoys as he awakes from it,
 without prostration. This plan of
 treatment is recommended by Dr
 McClellan who reports cases success-
 fully managed by himself. Several
 others have borne testimony to this val-
 uable remedy given in proper and repeated
 doses as a prompt and safe Agonic
'Quotid' from Titus.



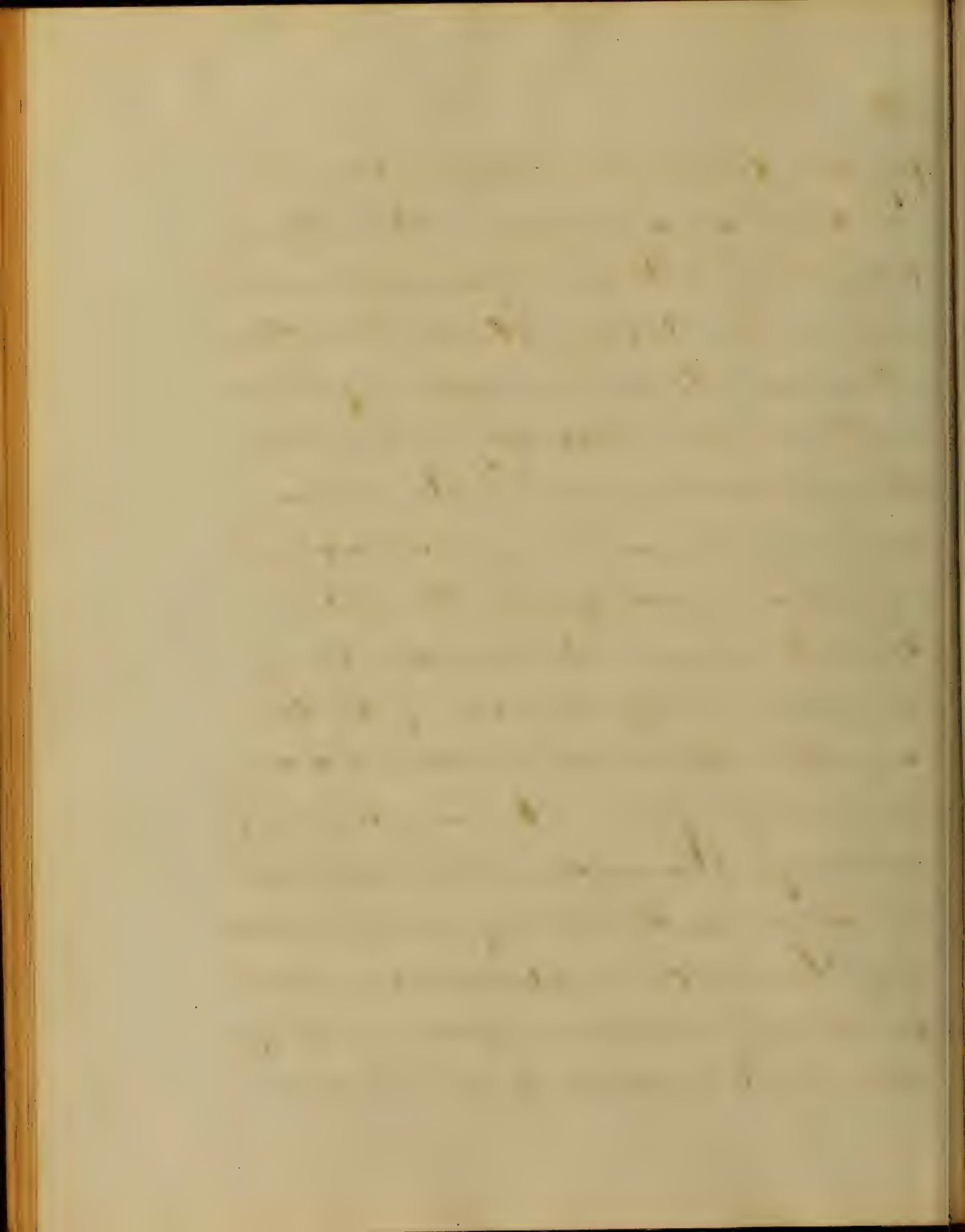
I think I will try this plan of treatment if I am permitted to try it. Though Quinia is the most reliable of all remedies, Arsenic given in Fowler's Solution is recommended, but this is too dangerous a medicine for patients to use by themselves. In reporting this case I did not think it necessary to inform you of the methods that are gone through by the physician to relieve patient - while suffering from the three stages. The patient can inform you what to do himself - and frequently they are their own physicians. The secret of the treatment is here - That the patients don't continue to ward off attacks by taking small doses of Quinia every morning for weeks -



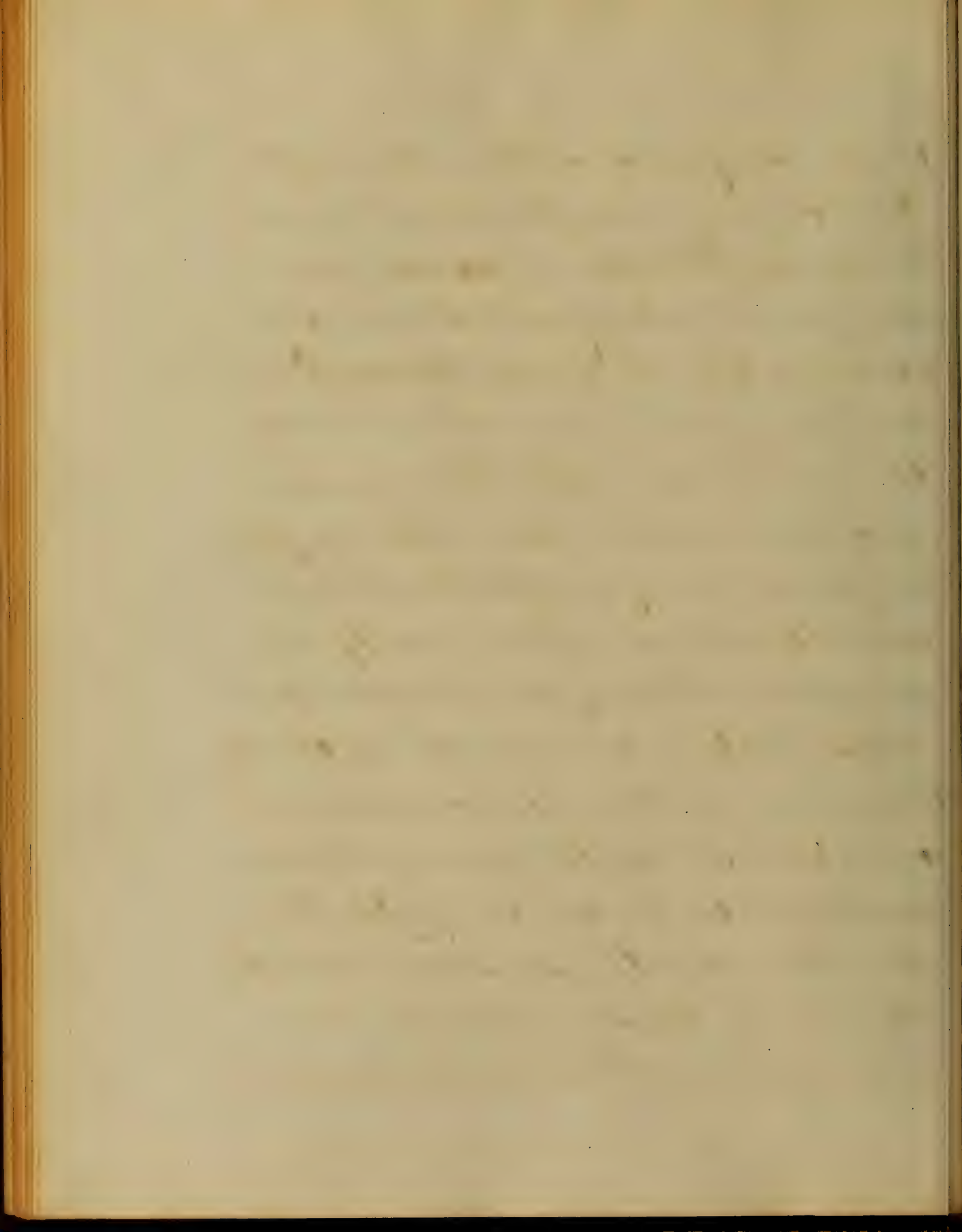
No. III.

May 13th Bournville. Laborer. Age 41.

Recd an injury about two years ago, at which time he was a Diabol, which caused him to be ruptured. Never gave him any trouble consequently he wore no truss. Last Monday he ate something that upset his Stomach and caused emesis, and under the violent efforts at vomiting a portion of the omentum was extruded, and being compressed by the sides of the opening through which it escaped was prevented from returning; this being a case of Strangulated Omental Hernia. Was admitted on the 12 of May and at five o'clock Prof Christhu Operated, incisions were made into the different coverings and an attempt at reduction which failed. He opened

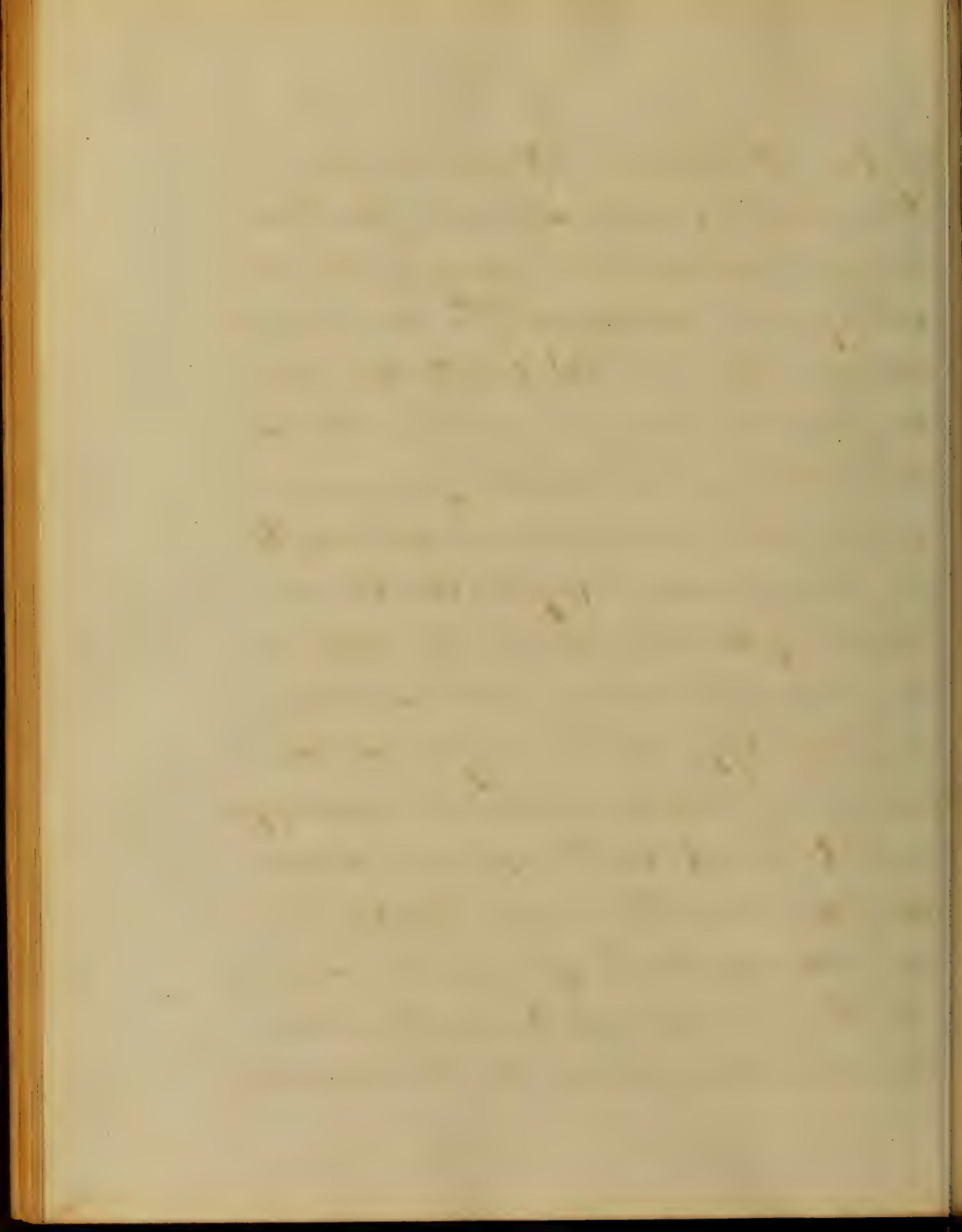


the eye and found it and the surrounding Mem-
 brane very much inflamed and congested,
 he excised. The external wound was
 closed over the stump and dressed with
 Carbolic oil. The 'Hospital' 'stand-Lys' the
 took full of opium every 3 hours but ob-
 tained very little sleep. This morning
 no improvement, pain extending up
 as far as ensiform cartilage. Temper-
 ature one hundred, Pulse eighty, all
 very little. Whisky and milk diet prin-
 cipally. Heat little increased during the day.
 Respiration shortened, pain in abdomen
 increased, and in the evening his pulse
 went up to one hundred and fifteen. Tem-
 perature one hundred and a quarter.
 Symptoms together with other sub-
 stantiate substantiate the diagnosis.



16

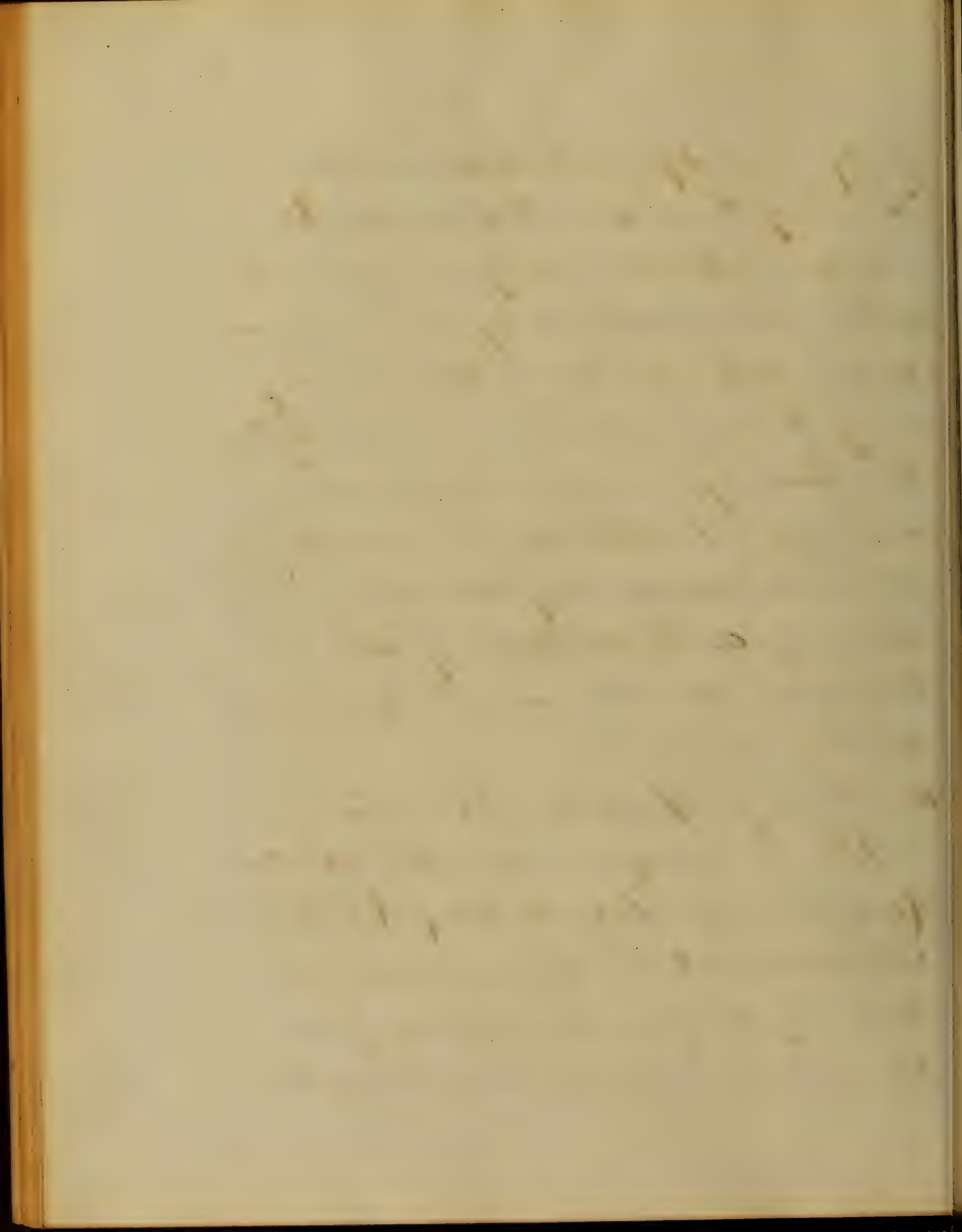
of acute Peritonitis of traumatic origin.
Opium in one and a half grain doses
were administered every few hours
along with whiskey. The external wound
was dressed with Carbolic oil and
a flaxseed poultice to his abdomen.
At bed time a quarter of a grain
of morphia was administered to
procure rest. May 14 Rested some
last night though felt weak. Ate
a piece of bread and drank a
cup of coffee. Pulse very small and
rapid so much so that it was impos-
sible to count it. Temperature one hun-
dred and one. Expression haggard
and anxious though no delirium.
Dr. Chas. called to see him and
said his pulse was one hundred and



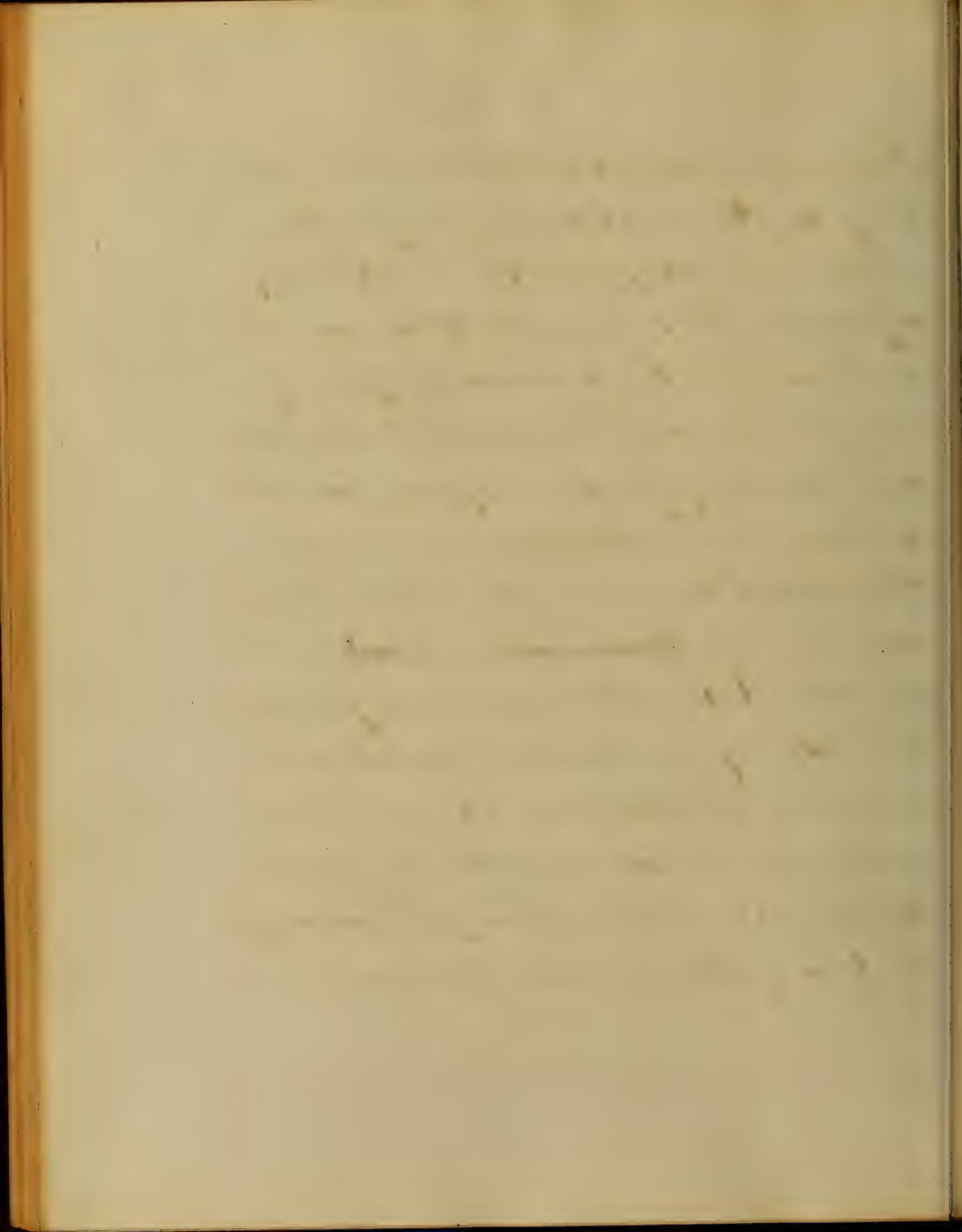
fifty or sixty; so he ordered him
 to ^{take} every hour and but bricks to his
 feet and extra covering on account
 of his coldness, also a hyperdormic was
 given after which he took whiskey
 every ten minutes, Four hours after
 the first hyperdormic a second was
 ordered, At 2 o'clock he was carried
 off in a paroxysm of vomiting, thus
 showing a short attack of acute
 Peritonitis, and his death by rapid
 asphyxia.

iv. Case of Sporadic Dysentery.

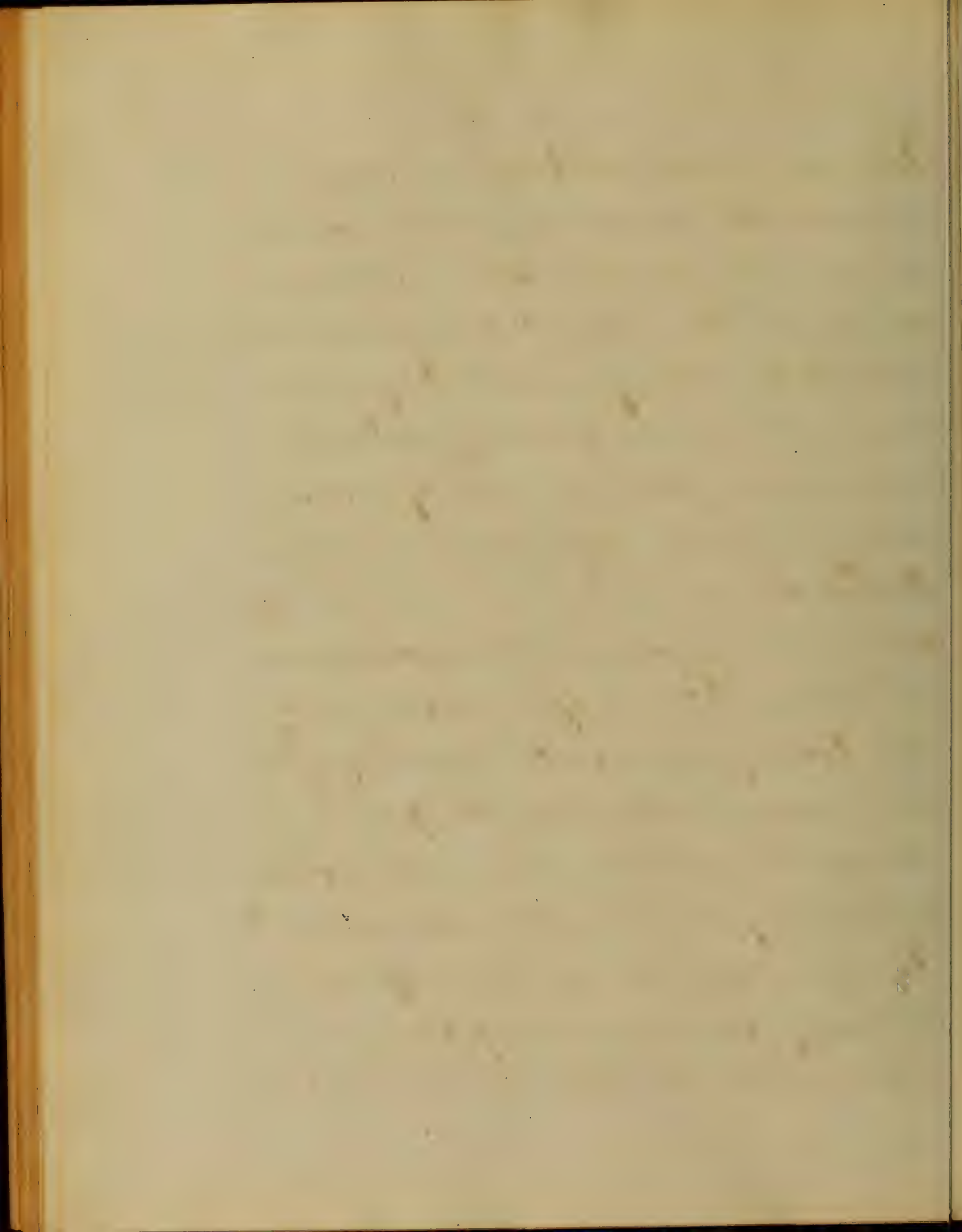
The following is a synopsis of the case
 Mary Jones Colored Age 30 - Occupation. Washwoman
 I was called to see this woman one day
 last July and found her suffering from
 the above disease. On interrogating her



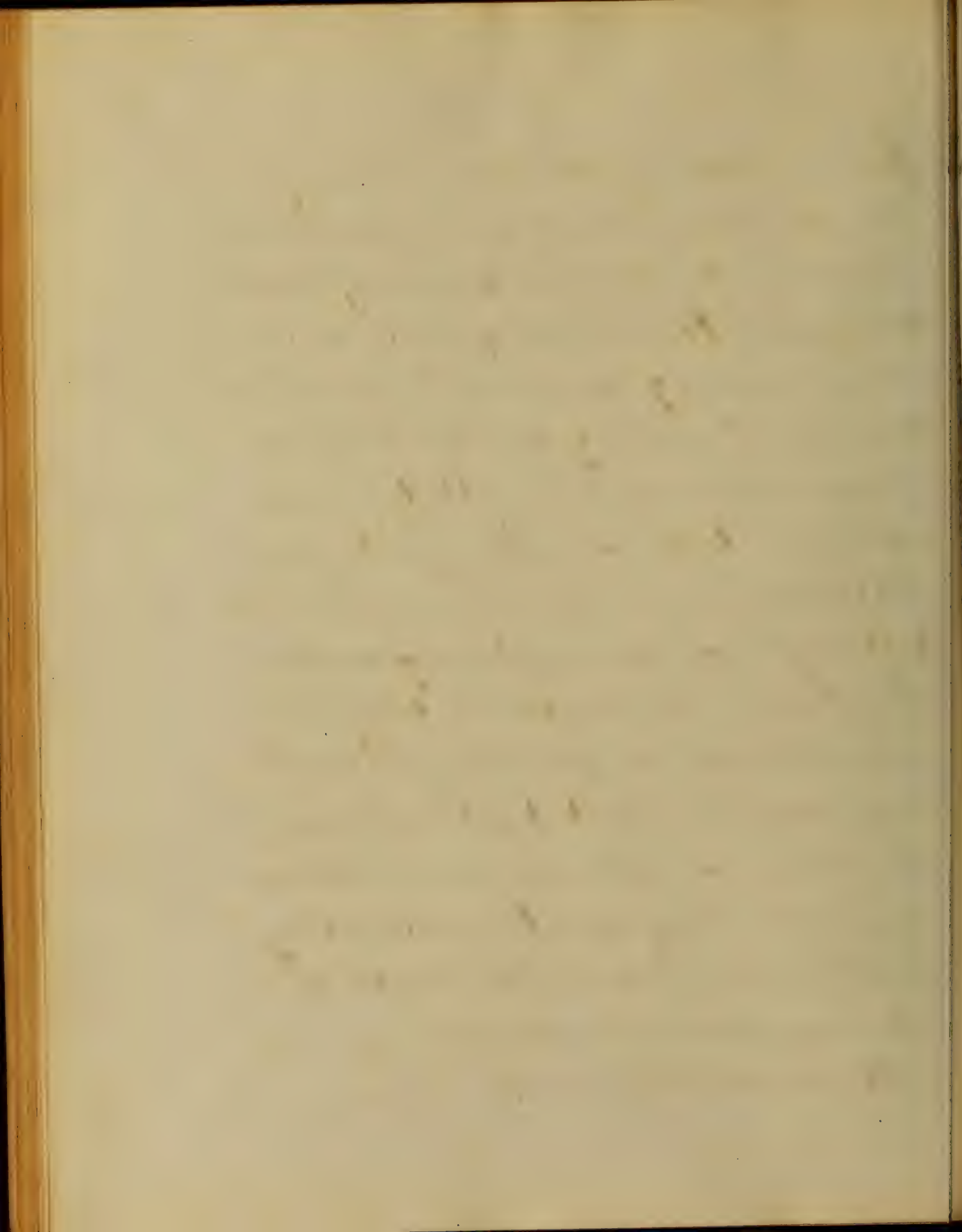
I discovered that - that she had been indulging in too much improper food and her surroundings not the best - the city afforded. She informed me the disease had come on in the ordinary form of a diarrhoea; that is, more or less discharge occurring frequently and frequent in character, as these dejections in nine cases out of ten precede the characteristic dysenteric evacuations, and now her calls to the stool were more frequent and bloody in character mixed with mucus; that the calls were attended with some pain and straining and towards the last nothing but a drop or two of bloody serum passed.



There was more or less tenderness on pressure over the descending colon, and more or less over the whole intestinal canal. Pulse not at all accelerated, with little or no fever. the Tongue was coated. She complained of extreme emaciation. Skin miserably hot, and some of the other symptoms peculiar to this disease were present, though these were sufficient for a diagnosis. Sporadic Dysentery is a disease if left to itself will in the majority of cases recover. But as the people at large bliss in medicine, used it, especially as I was very anxious to try ipecoc. Since this speaks of it highly and a remedy that John Helvetius the grandfather of the



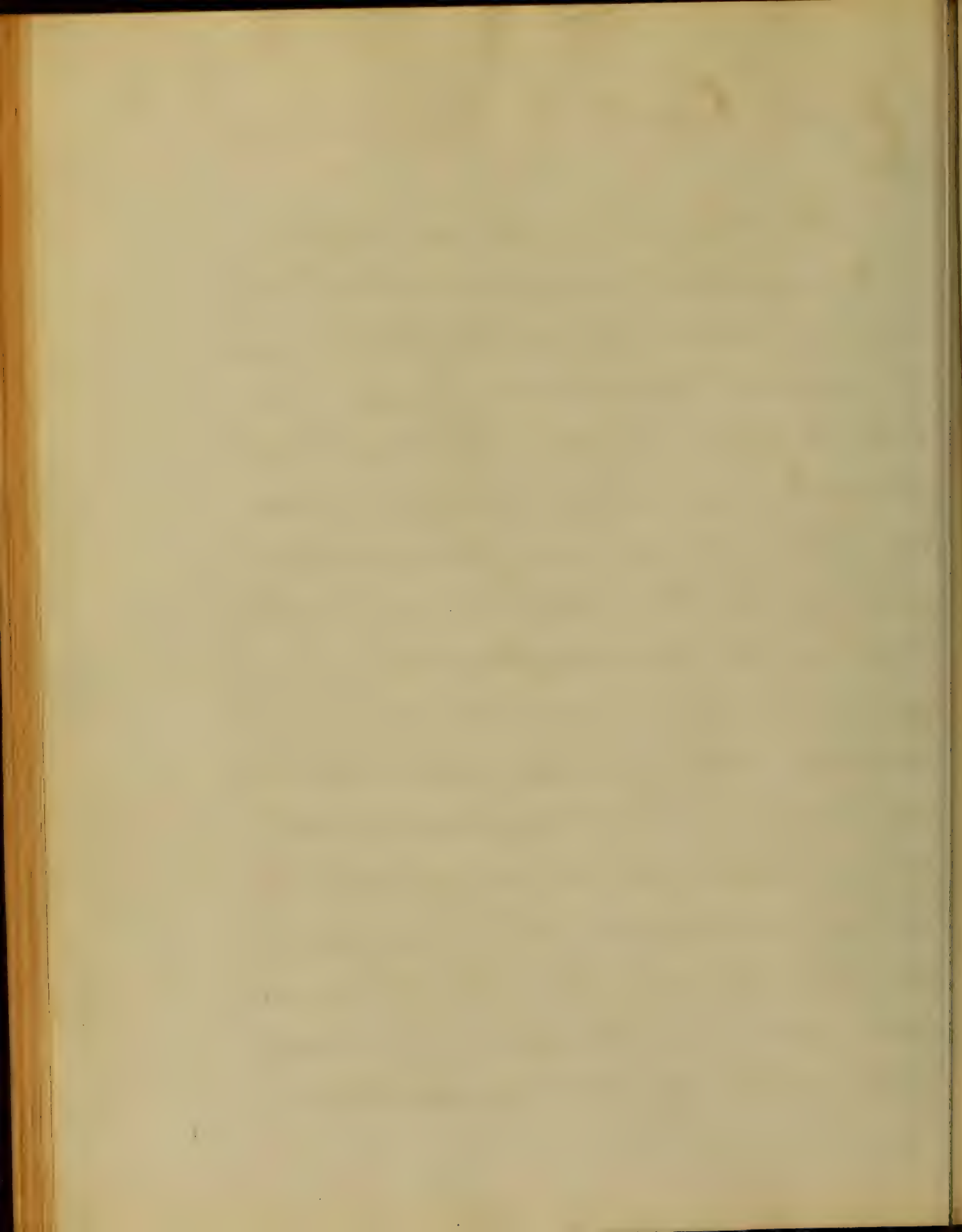
famous author of that name having
 been associated with a merchant who
 had imported a large quantity of that
 drug into Paris, employed it as a
 secret remedy and with so much suc-
 cess in Dysentery and all bowel com-
 plaints, that general attention was
 drawn to it and the fortunate
 Physician received from Louis the
 XIV a large sum of money and pub-
 lic honors on condition that he
 should make it public. Though I
 was advised not to try this plan of
 procedure as it was rather danger-
 ous, not being able to watch its ef-
 fects, but I could not let the oppor-
 tunity pass. So made up my mind
 to adopt this remedy



Mr. H. Age 50.

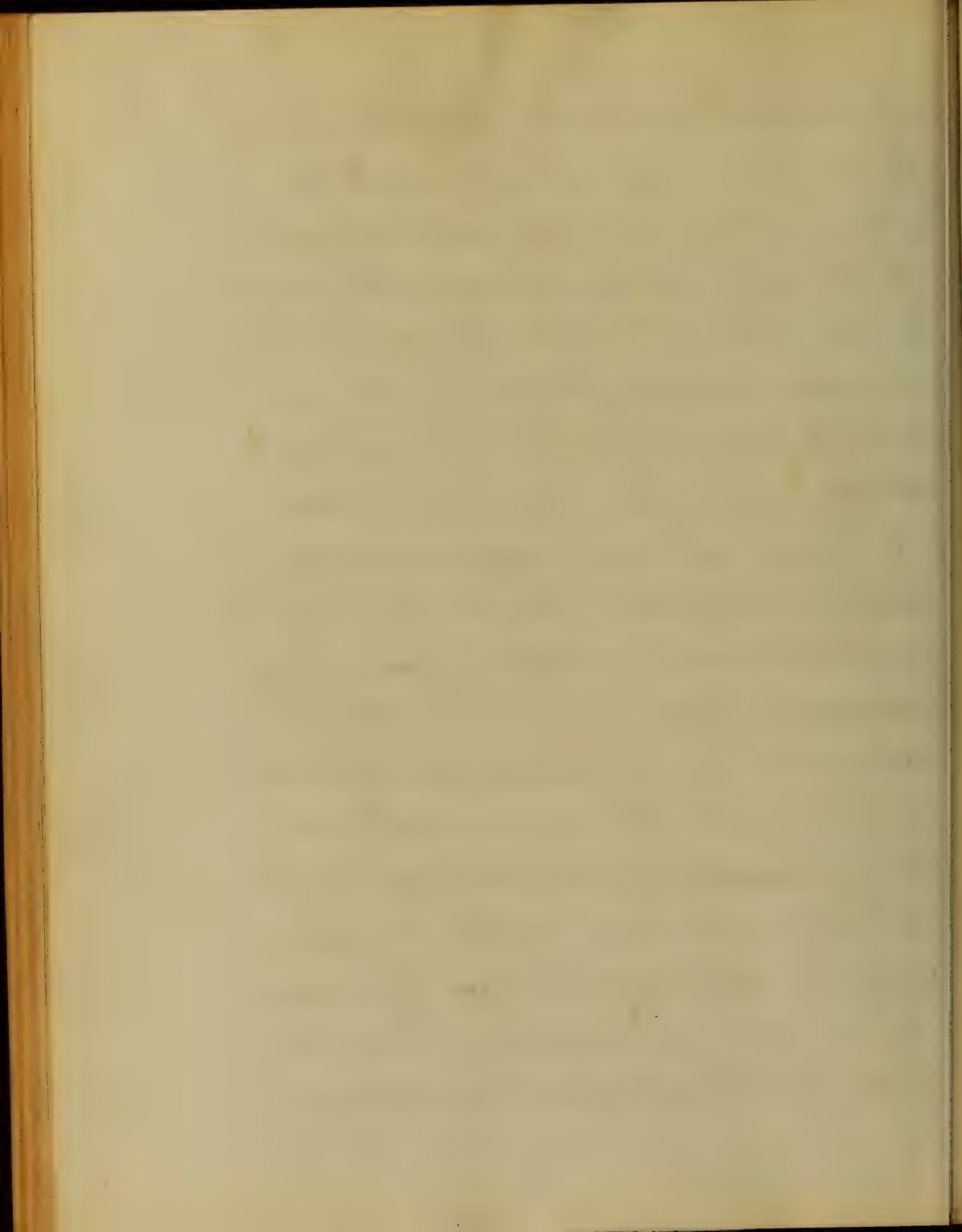
Aug. 24th

This lady had an opportunity of witnessing last Summer with my father laboring under her usual attack, Asthma. He went in the room and found her unable to place herself in the recumbent position, and requesting fresh air and resting her elbows upon her knees part of the time, the remainder on the sides of the lounge; perpiration was profuse; expiratory act was prolonged, and accompanied with a loud wheezing in tone; inspiratory act was rather spasmodic in character, which is the pathognomonic sign of this terrible disease. Her pulse was small due to obstruction of pulmonary circulation, by an accumulation of

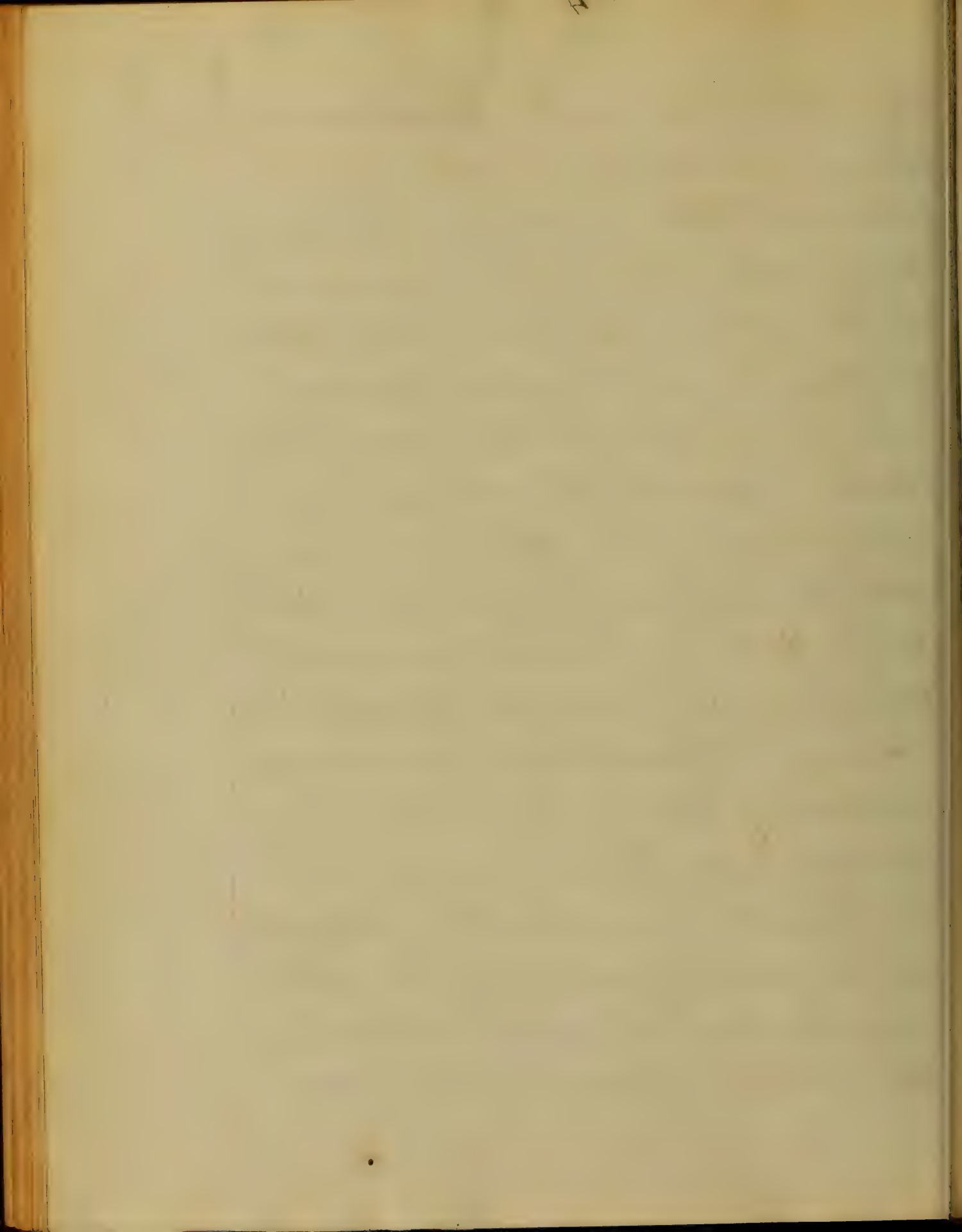


Blood in the right cavities of the heart.

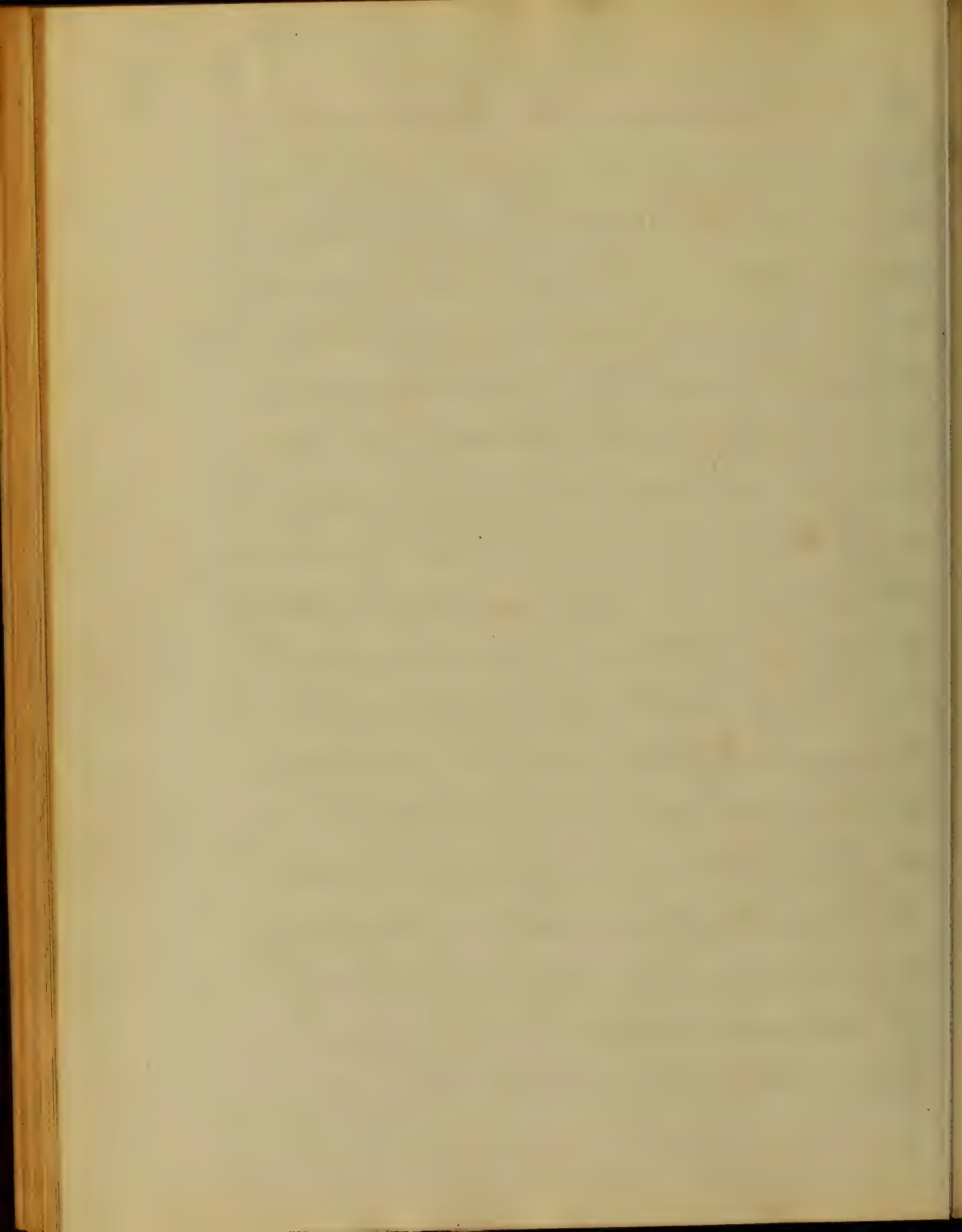
Very little cough existed prior to the paroxysm, it is generally a sequel, lasting for several days. She dreaded to move her body, as the change of position increased her suffering. Countenance extremely anxious, she inquired as to the cause and found that her husband an uncouth - and rough sort of an individual came in the house out of humor, and using profane language consequently putting every one in various conditions and especially his wife, which we ascribed ^{as} the cause of the paroxysm. She was given Sulphur ether to inhale and a little some few minutes internally to relieve the paroxysm which accomplished it in the course of a half hour, after that she went



off into a tranquil sleep, and in the
 course of a few hours afterwards
 she was taken with an other parox-
 ysm this they relieved according
 to the plan my Father had adopted,
 I said this was brought on by a ner-
 vous condition, still there was a foun-
 dation for this to act upon and
 that was a bronchial affection.
 Some think it is a neurotic affection,
 others date an essential fever, and by
 others still it is considered a peculiar
 variety of bronchitis. In fact it is neither
 separately but each one entering into
 the disease, The remainder of the
 treatment was Solas Ed & Hoar Bro
 which gave her great relief. These I asked
 my Father to try which he did to suc-
 cess, I think he adopted other measures

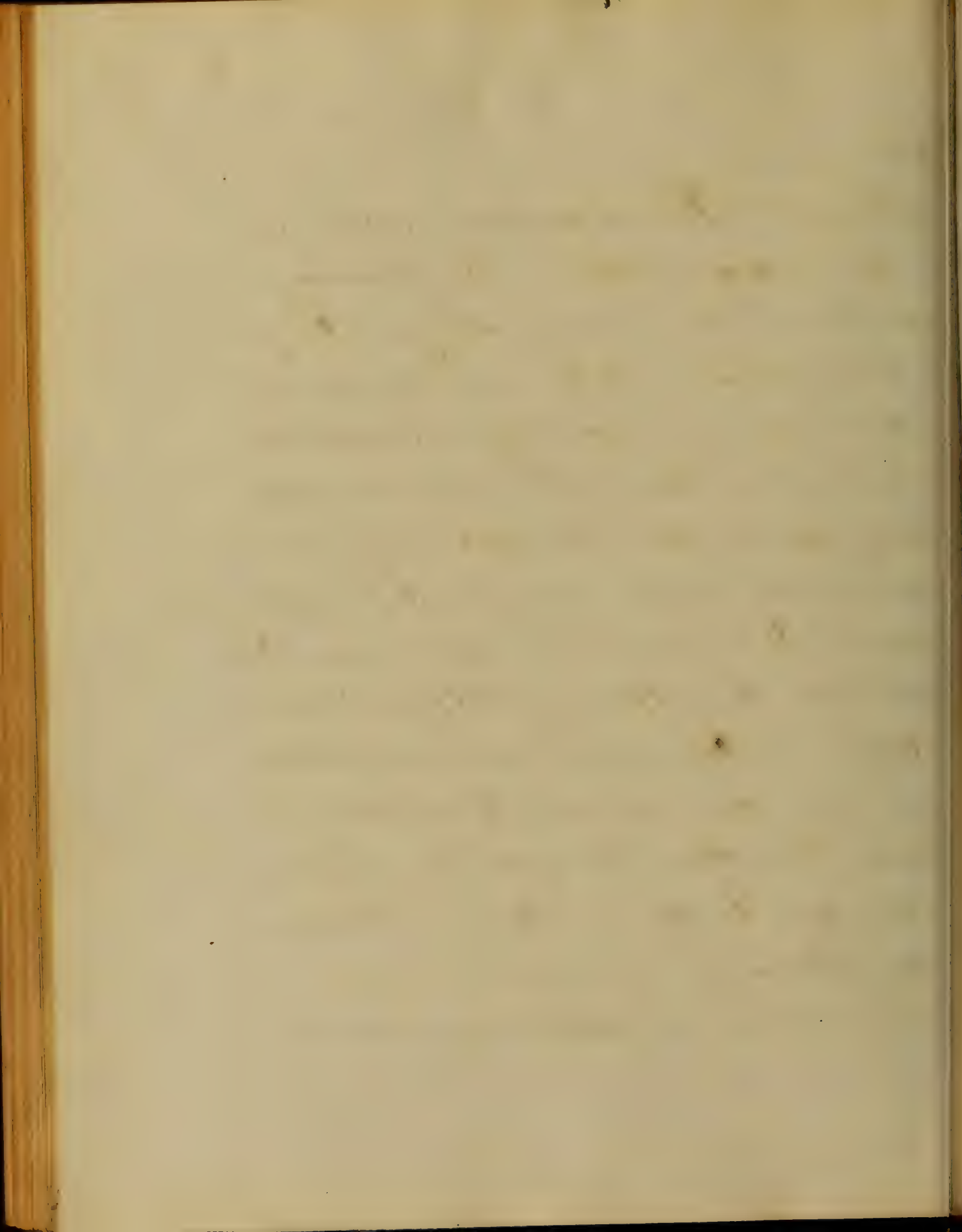


for treatment which were given when I was out, though the Potash was renewed several times by them, Prof Chew says give a person suffering in one of those forms, a hyffperdermic of Morphia - and it will instantly afford great relief. Tinc Belladonnae in 10 ~~gr~~ doses is recommended by several, repeated every two hours until vision is disturbed. Stramonium is highly spoken of, especially smoking the dried leaves, or fibres of the root either in the pipe or in cigarette form. Many are the ways to treat it, and this lies in the hands of the proctitioner, if the patient has not learned herself, which is frequently the case as they suffer such agony, that almost instant relief is required before medical aid arrives.



Sept 24
1864

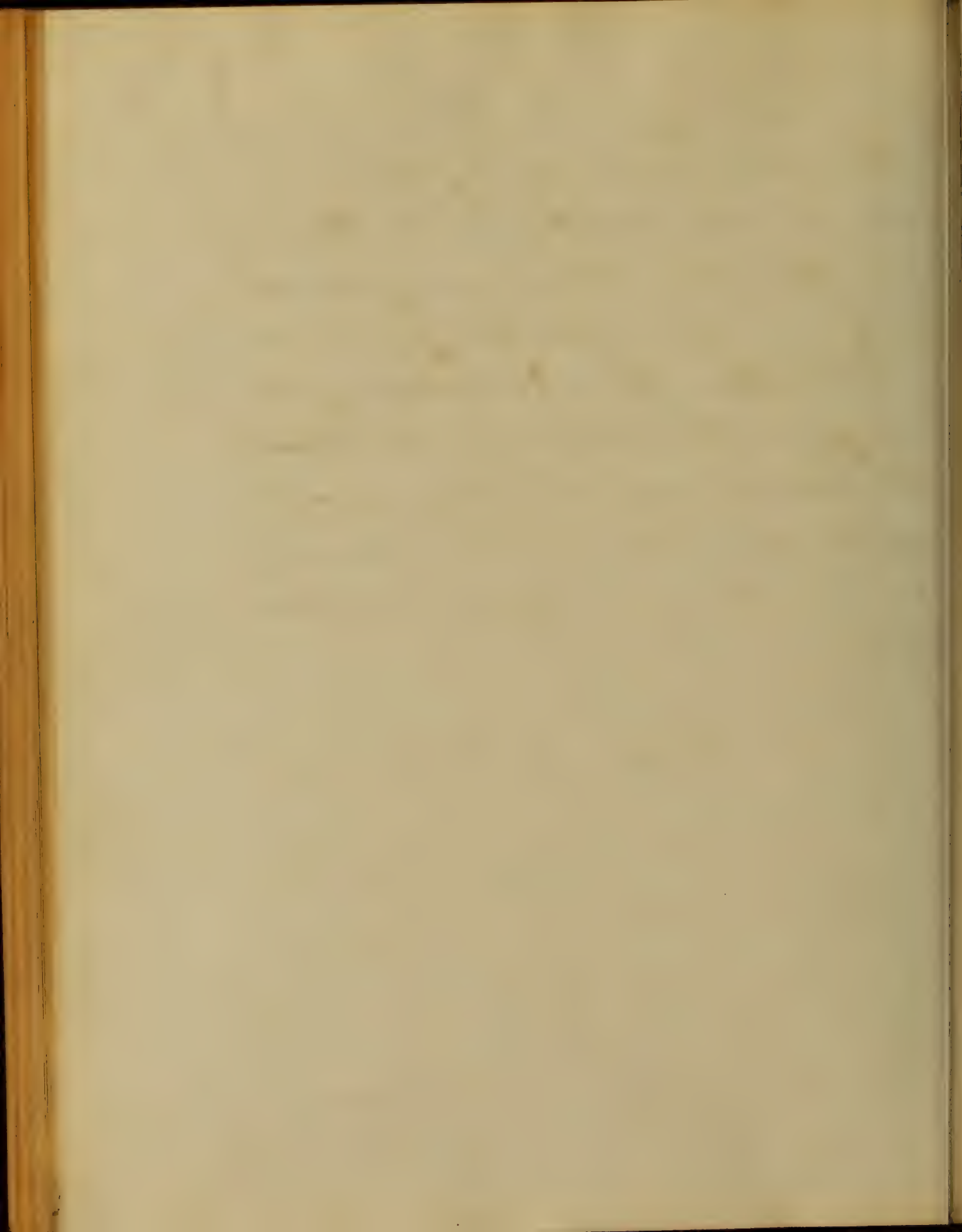
This is a case of a young girl age 15 years suffering from a severe chill every day or two for a week and afterwards on aching in her bones, head pained, and general prostration, She has been laboring under this condition for several weeks before my attention was called to her case, In the mean time she had been taking Dr. Ayer's celebrated ague mixture, which answered the same purpose that most all Quack medicines do. This girl being at home I had an opportunity of watching her case and trying my skill. Her chills were rather longer than



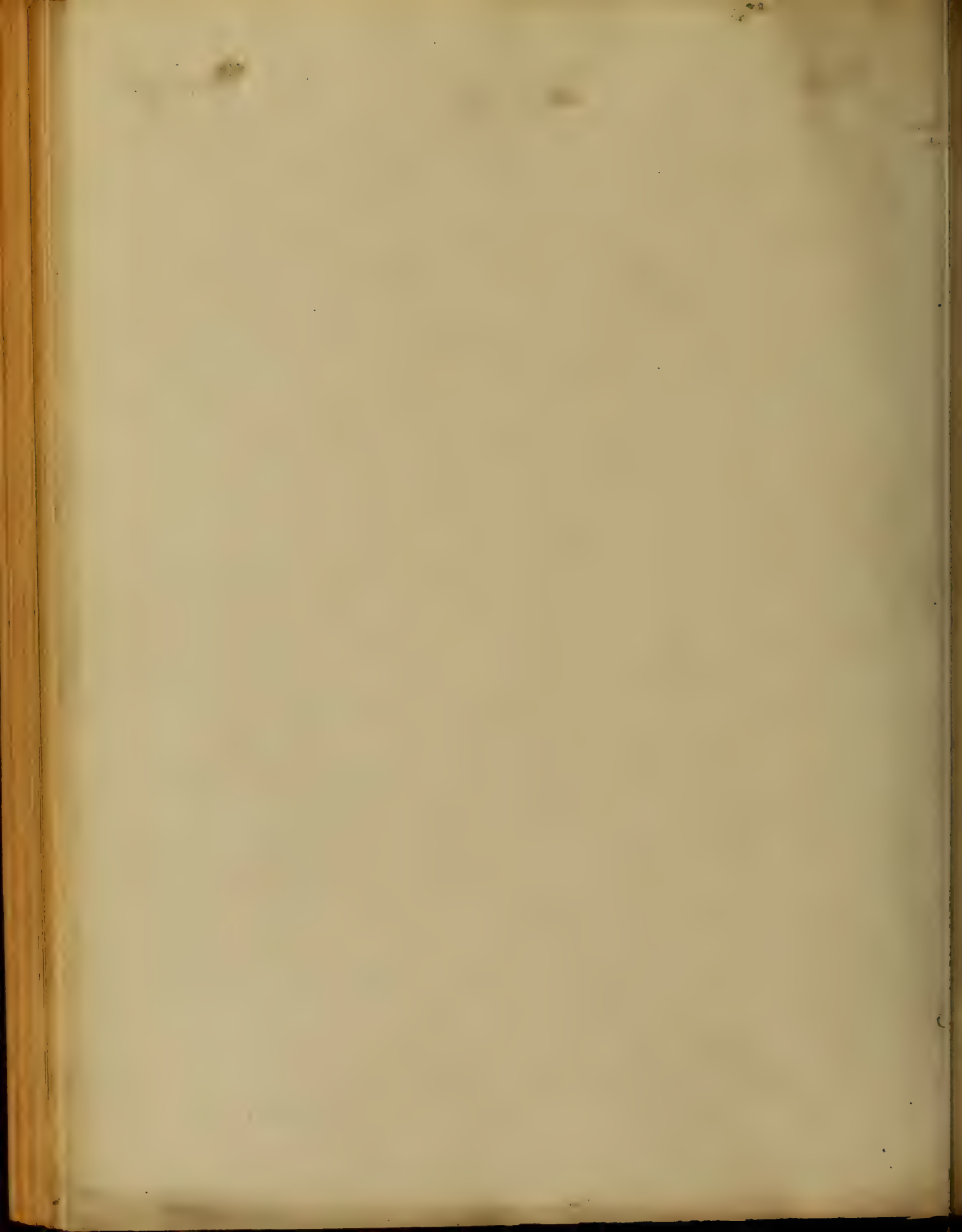
the general run, and fever high accordingly, Not having a thermometer with me was unable to ascertain her temperature, I thought as Fowler's Solution was rather a cheap remedy, advised her to get it and take three to five drops three times a day, and gradually increase until eight or ten had been taken, This plan was continued for two or three days with a decided improvement so I stopped and commenced the Quinia Sulphas in five grain doses for the first two at five hours interval between the doses and after that three grs were administered with a little milk 'as it left such a bad taste and this seemed to satisfy her' until sixteen grs ~~had~~ been taken during the twenty four hours.

From this I immediately got good results and continued the Quinia in two grain doses every morning for two weeks along with a little Iron three times during the day for the purpose of strengthening her, & at the expiration of a week she felt rather like a robust person and so continued, as long as I could hear of her.

Travis,



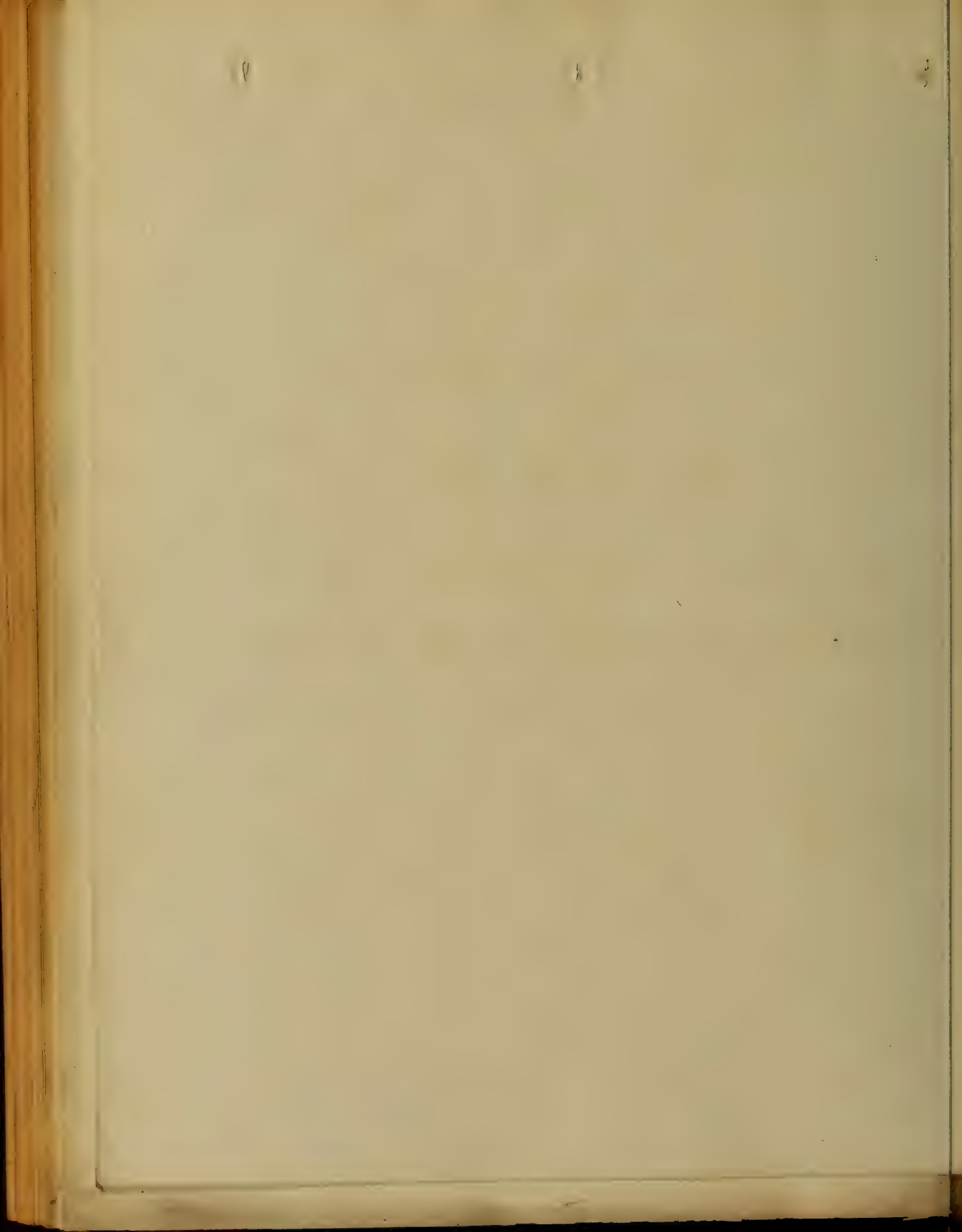




A Thesis on
Acute Croupous Pneumonia
By

John B. Butler

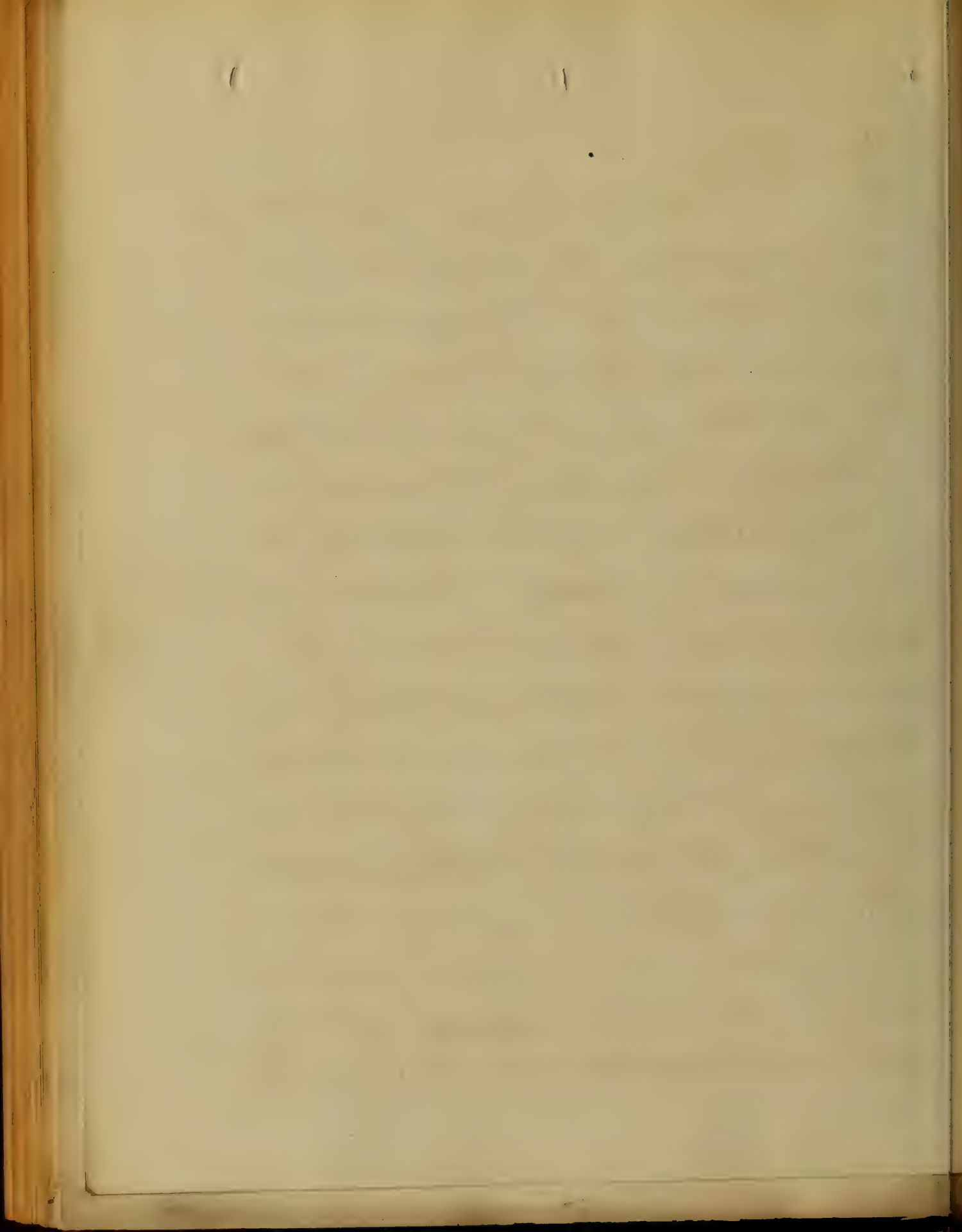
Presented to the
Professors of the University
of Maryland. School of Medicine
February - 1877



Gentlemen.

In compliance with the rule respecting the preparation, and presentation, of a "Thesis", I submit to your respectful consideration the following, on the subject of Acute Croupous Pneumonia.

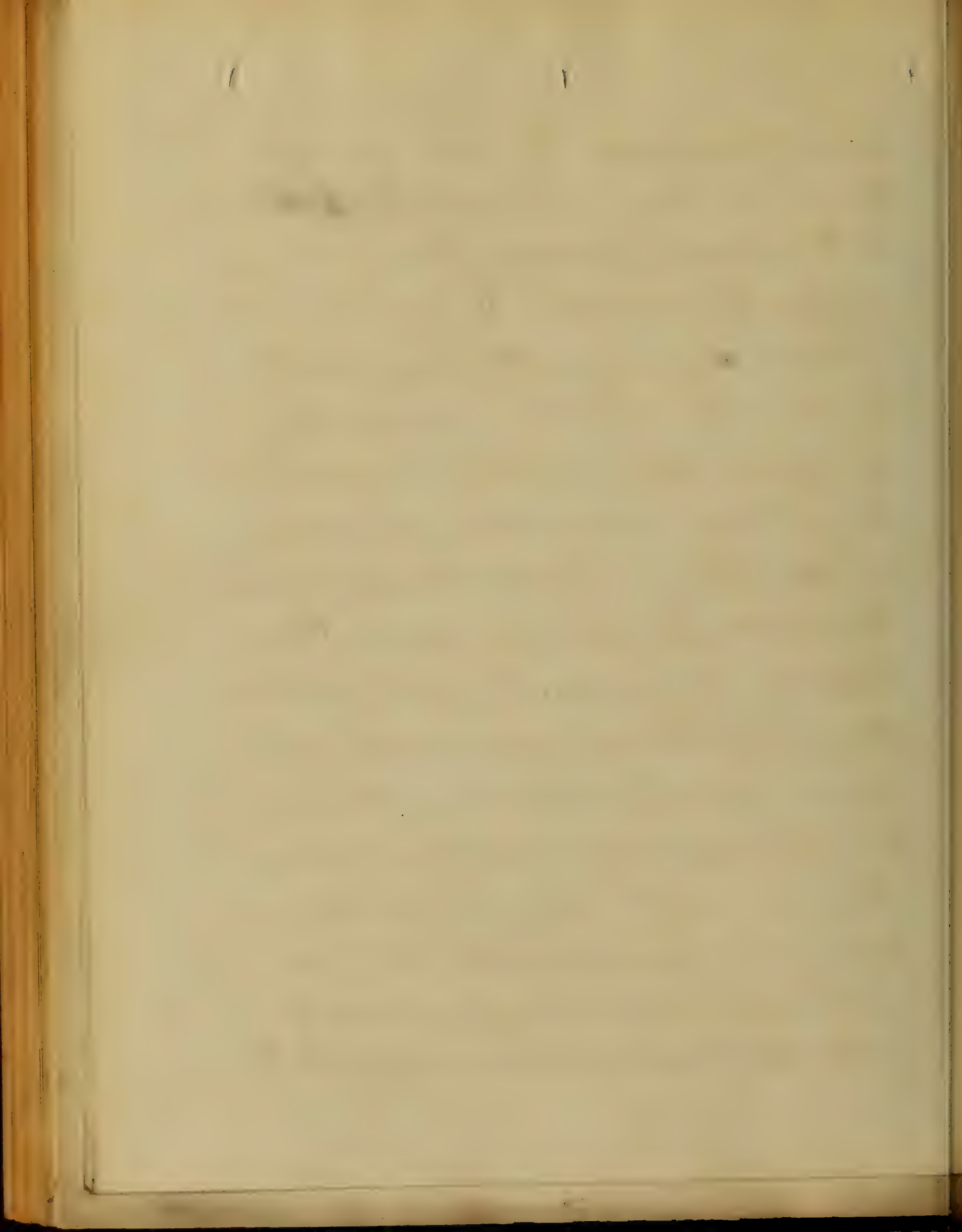
Definition. - Inflammation of the parenchyma, or spongy substance of the lungs. Croupous is applied to this form of pneumonia on account of the exudation resembling that of Croup, being tenacious, and containing fibrin. It also distinguishes it from another form, called Catarrhal pneumonia. The exudation in which, contains no fibrin. In Croupous pneumonia one entire lobe is usually affected and very often more than one lobe. Hence it is called



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lobar pneumonia. The lower lobe of the right lung is the seat of inflammation in the majority of cases. though it is frequently found in the lower lobe of the left side, and in a pretty large percentage of cases it attacks primarily — an upper lobe of either the right or left lung. When a lobe or more on each side are affected it is called double pneumonia.

Morbid Anatomy. In pneumonia three stages are recognized, the first is called that of congestion or engorgement the capillaries become greatly distended with blood causing dyspnea or difficulty of breathing though in this stage the function of respiration is interfered with, yet the air is not prevented from entering the air-cells. There is a slight effusion of viscid albuminous fluid into the



alveoli. The lung substance in this stage presents a dark red, or a deep red appearance. On section the blood flows freely from the cut surfaces.

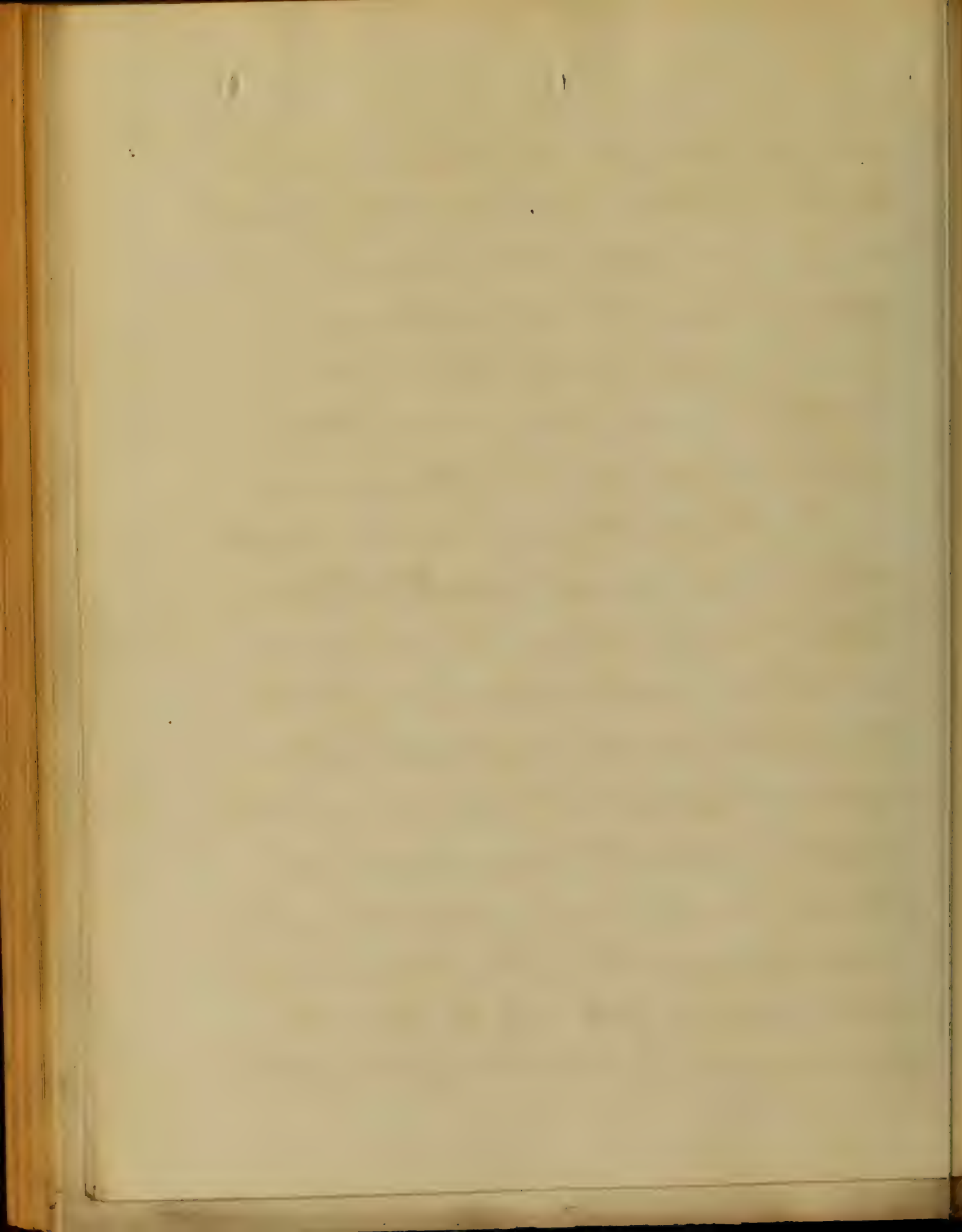
The second stage is known as the stage of red hepatization. It is characterized by an exudation into the air-cells which escapes from the blood through the small apertures in the walls of the capillaries.

This exuded matter containing fibrin, when poured out into the air-cells, coagulates, becomes solid, and excludes the air from the air-cells, or vesicles, the lung substance in this condition, is red, solid, and heavy, presenting the appearance of liver, hence its name "hepatization", from its resemblance to liver. When a piece of the hepatized



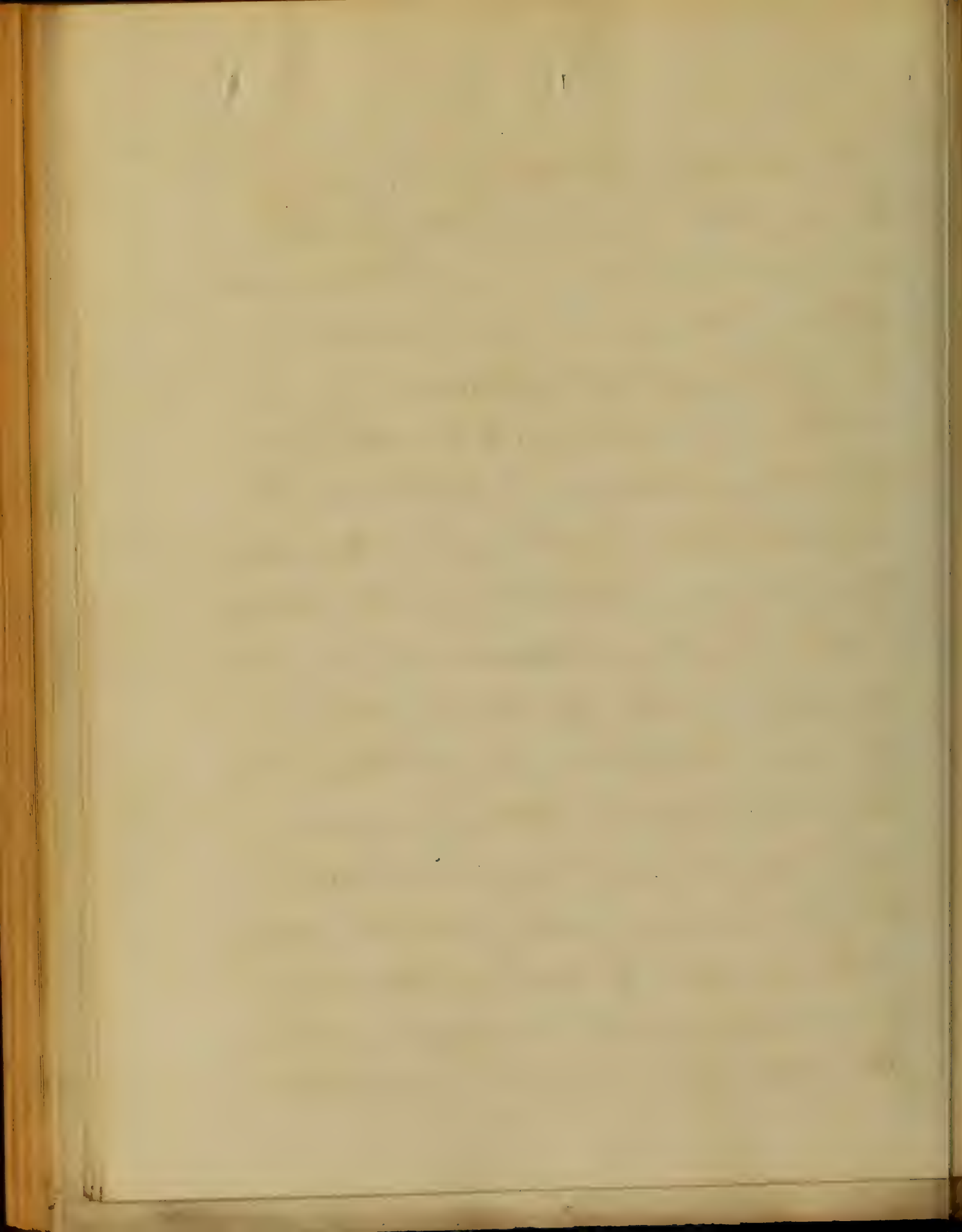
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lung is put in water it readily sinks to the bottom of the vessel. The cut or torn surface, has a granular appearance. The substance of the lung is more friable than it is in health, breaks down under the pressure of the finger.

The third stage is known as the Stage of Gray hepatization, Called some times the stage of resolution, or absorption. In this stage the capillaries, are compressed by the inflammatory deposit. The red coloring matter disappears from the coagulated mass. Pus begins to form - fatty degeneration and liquefaction takes place, and if the disease progress favorably, the liquid pus is soon removed by absorption and expectoration.



The air-cells remaining uninjured during their engorgement. The function of respiration is immediately resumed, But if the course of the disease be unfavorable the fibrous liquid matter is not absorbed, and the lung substance becomes infiltrated. This is called purulent infiltration. Sometimes pus is collected in the substance of the lung, and abscesses are formed. Gangrene of the affected portion of the lung takes place sometimes but this rarely occurs. When gangrene does take place, it may be detected by the gangrenous fetor of the breath.

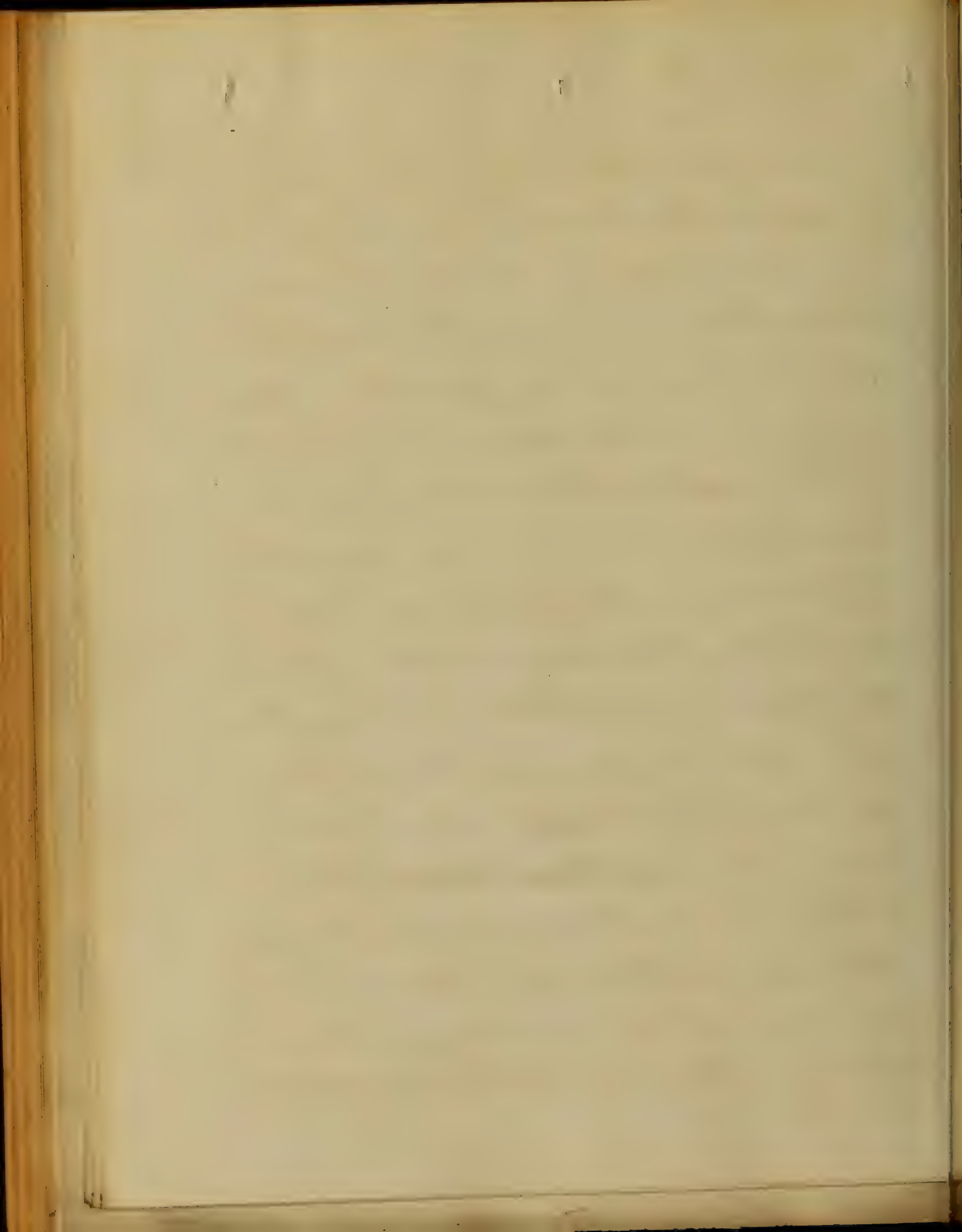
The duration of each of these stages varies considerably in different cases. The stage of congestion generally



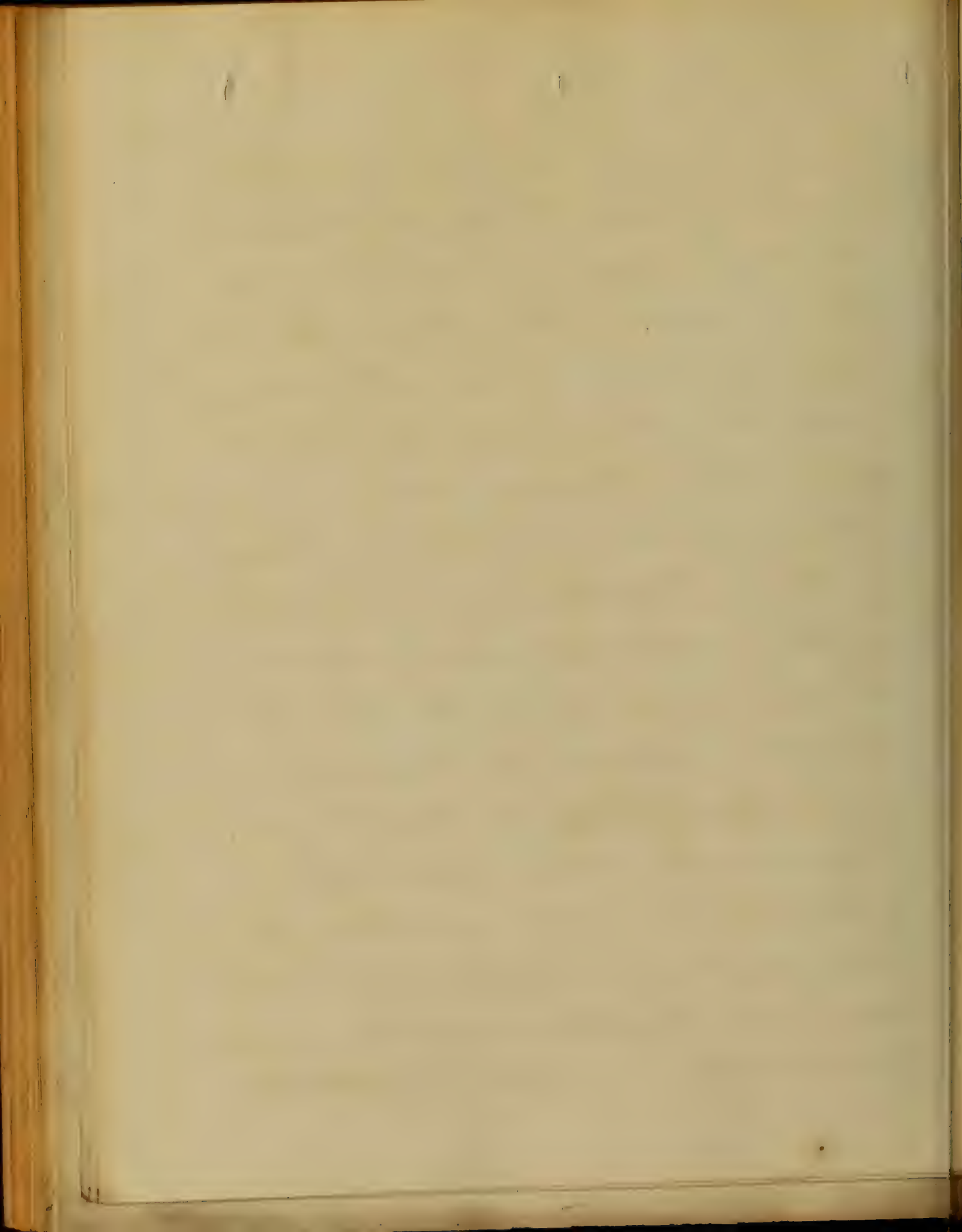
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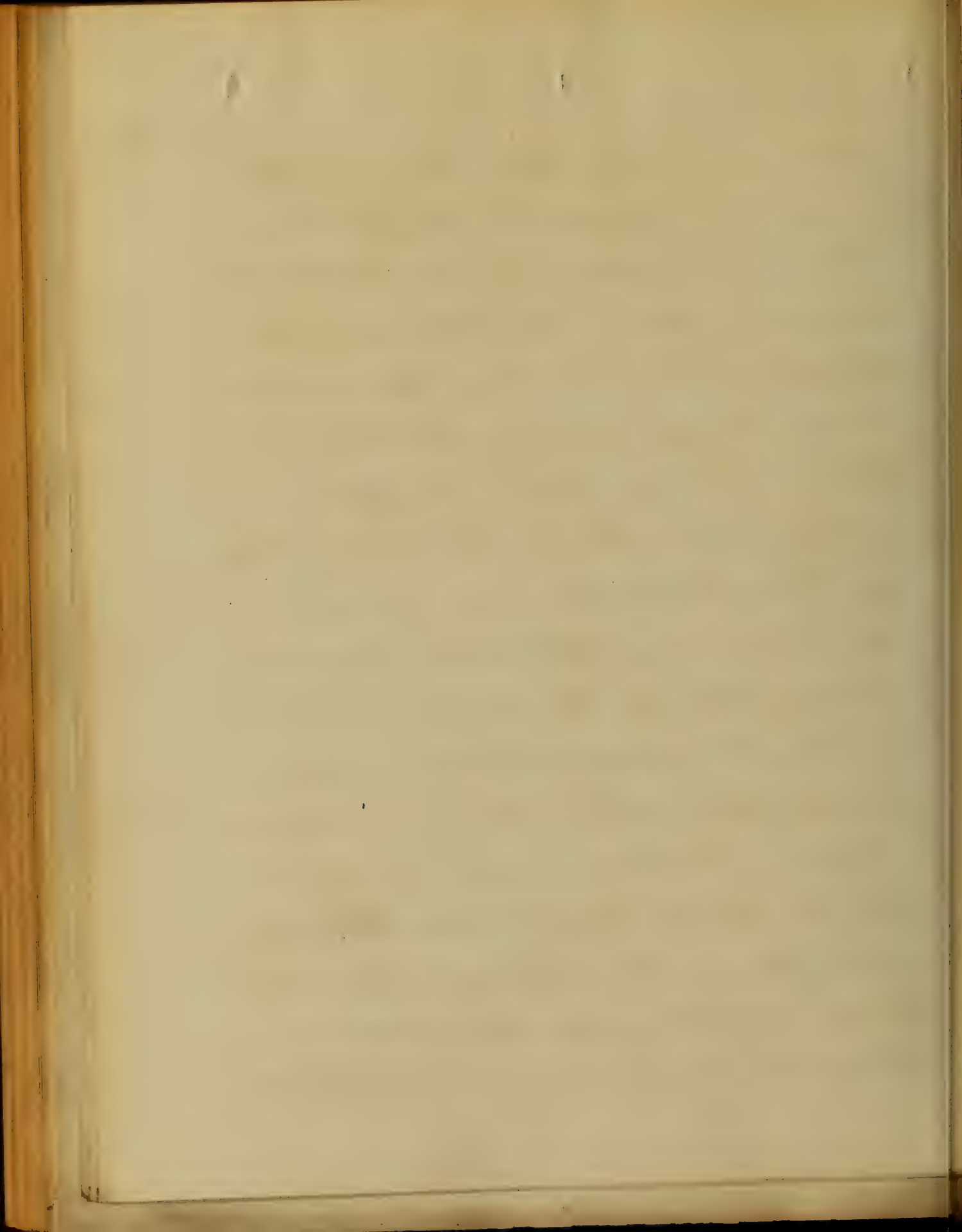
lasts from twenty-four, to
forty-eight hours. Sometimes
the duration is shorter and
sometimes longer. The congestion
commences at one point in the
lobe and extends from lobule to
lobule until the whole lobe is
involved. And it may be seen
by examining the lung of the
patient that dies in this stage
of pneumonia. That solidification
often commences in the portion
of lung first affected, before
congestion has extended over the
entire lobe, thus it will be seen
that a portion of the lobe is
in the state of congestion
while the other is in the state of solidification.



The second stage, or stage of solidification usually lasts from two to four days, though sometimes it is much shorter than this, and sometimes longer, The third stage or stage of resolution, usually lasts from three to six days, though often it last ten days, and even longer according to the constitution and strength of the patient. So we find the duration of this disease variable. In cases that progress favorably, the average duration is from ten to fifteen days. Symptoms. In this form of pneumonia, the attack is generally sudden with a chill in the night. From the beginning there will be high fever, headache, nausea, and vomiting, with hurried respiration, and frequent pulse. There is often a perspiration of the face, of the

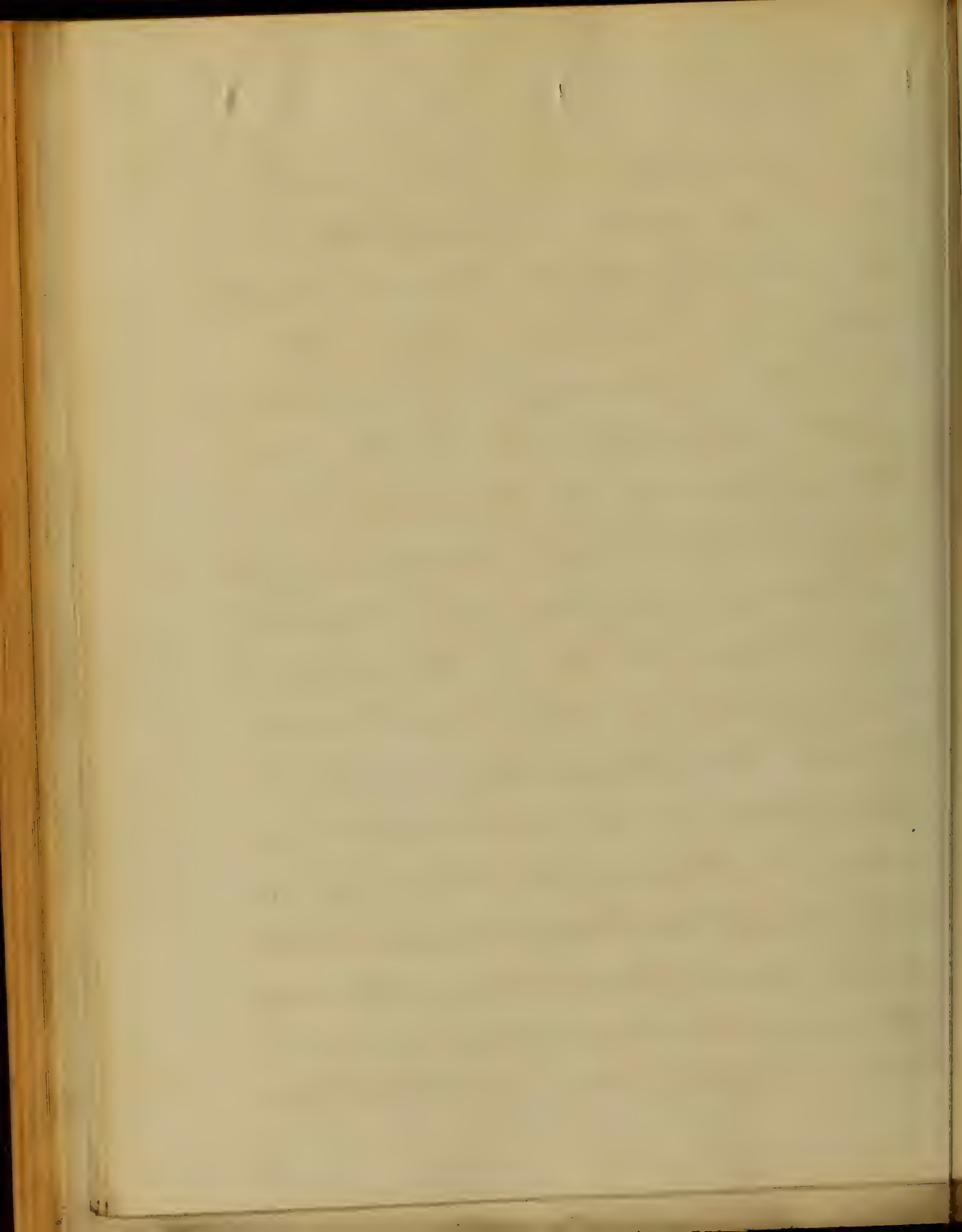


pulse and respirations the respirations being more frequent in proportion, There is marked elevation of temperature ranging from 102° to 104° F. Sometimes reaching 106° or 107°. It is then regarded a very dangerous symptom, The skin is dry and hot. Dyspnea or laborious breathing with dilatation of the alae nasi, are very — common symptoms in pneumonia, especially in the severe cases, as in double pneumonia, or even when one entire lung is involved, Pain is a prominent symptom, in the majority of cases, though sometimes it is very slight and even wanting in some rare cases. The pain is acute, lancinating and



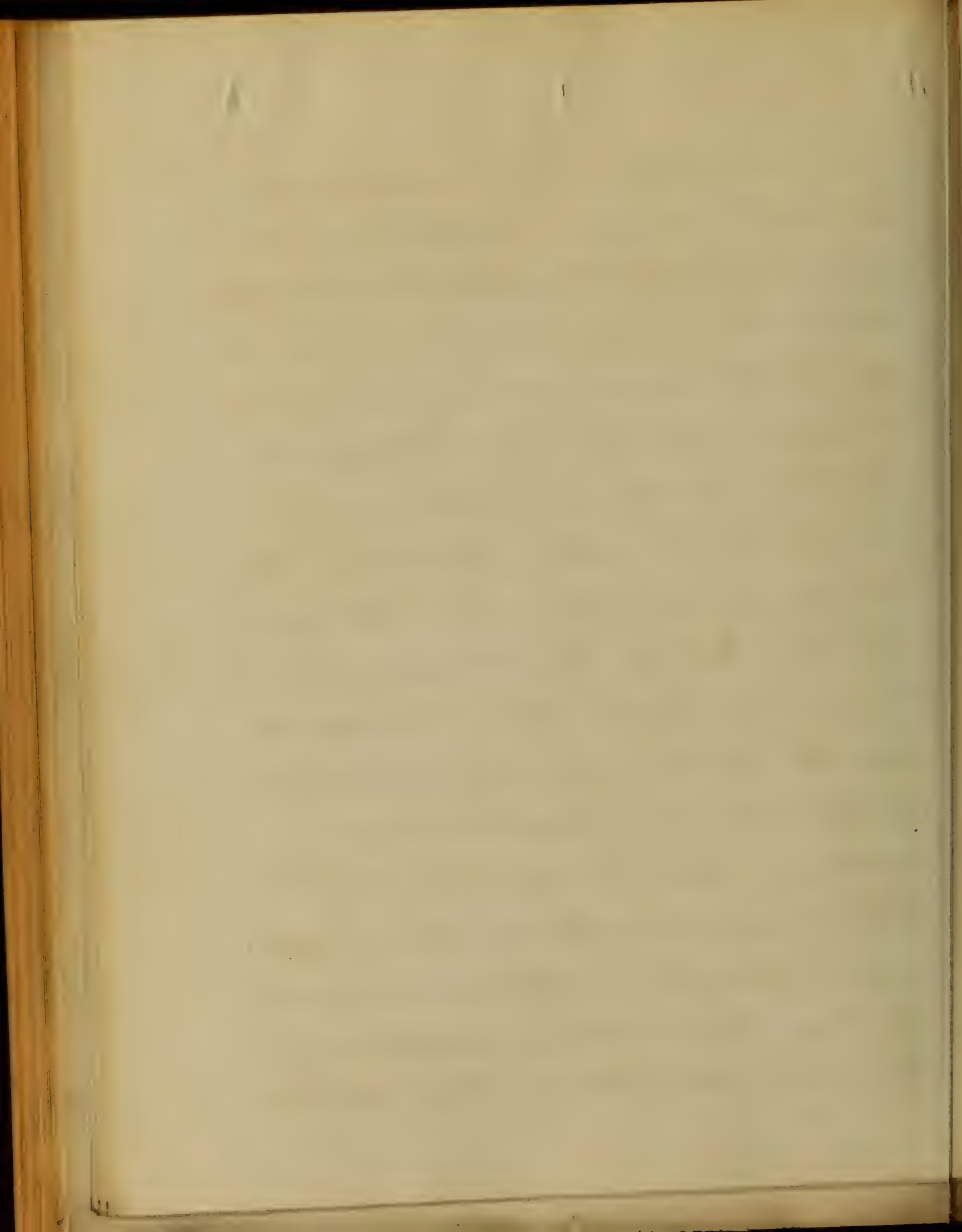
is referred to a limited space about the nipple usually. It is due principally to pleuritic complication, and when the co-existing pleurisy is persistent extending beyond the limits of the inflamed portion of the lung, it is called pleuro-pneumonia.

The cough in pneumonia is usually troublesome, at first dry and more or less painful. Sometimes it is absent. The expectoration is at first scanty and viscid, in the majority of cases it is tinged with blood known as the rusty sputum of pneumonia. In some severe cases, the sputum is thin, deeply stained with blood, and dark colored — known as the prune juice expectoration.

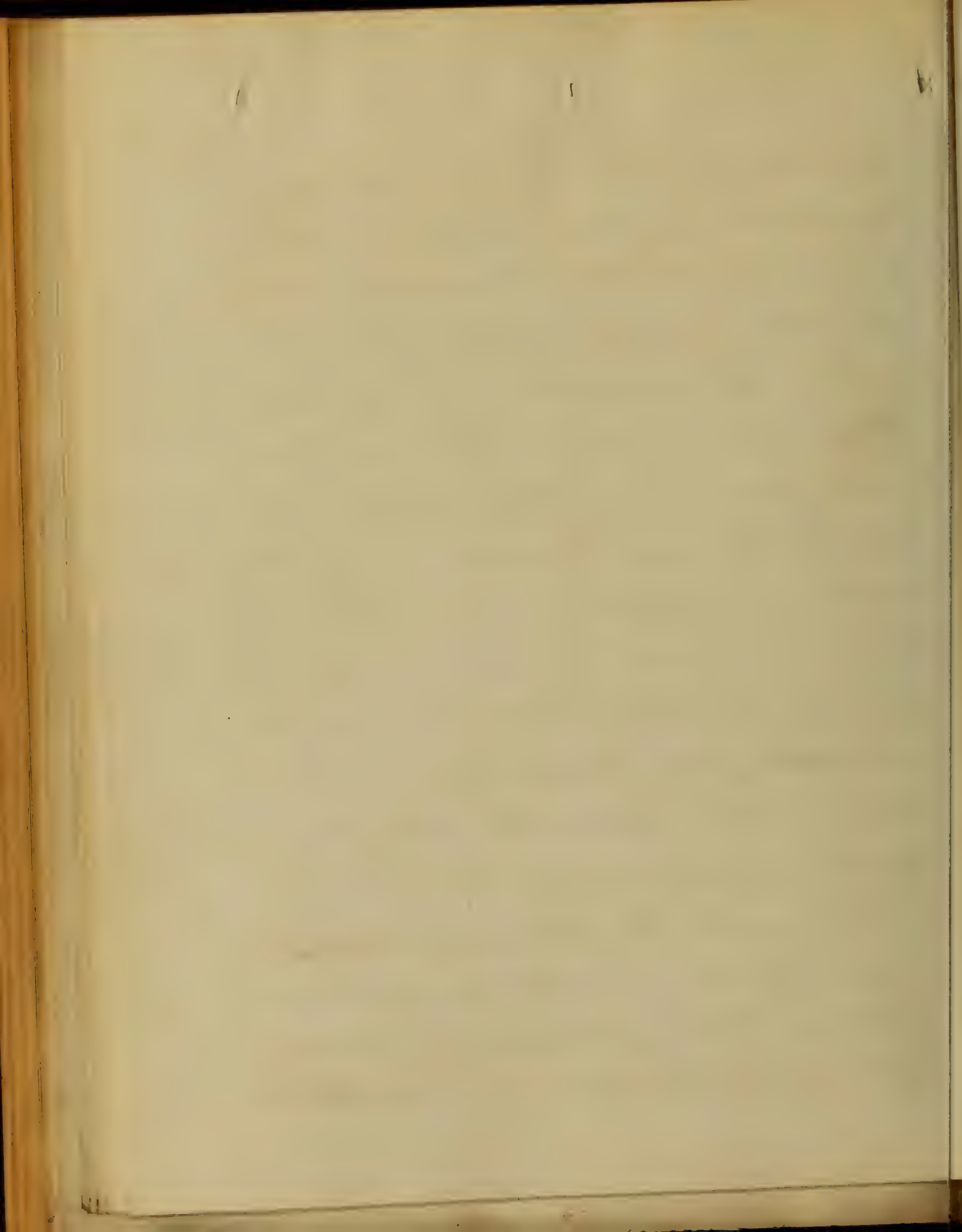


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The urine in pneumonia is scanty, high colored, and from the time exudation commences until absorption of the inflammatory deposit takes place, there is a disappearance of the chlorides, which may be ascertained by a solution of the nitrate of silver, previously acidulated with a few drops of pure nitric acid by the application of this test, if the chlorides be present, they will be manifested in the form of a cloudy precipitate, if they be absent no change at all will be produced upon the urine by the test.

That the exuded matter contains a certain amount of the chlorides is evident from the patient's complaining of a saline taste in the mouth.

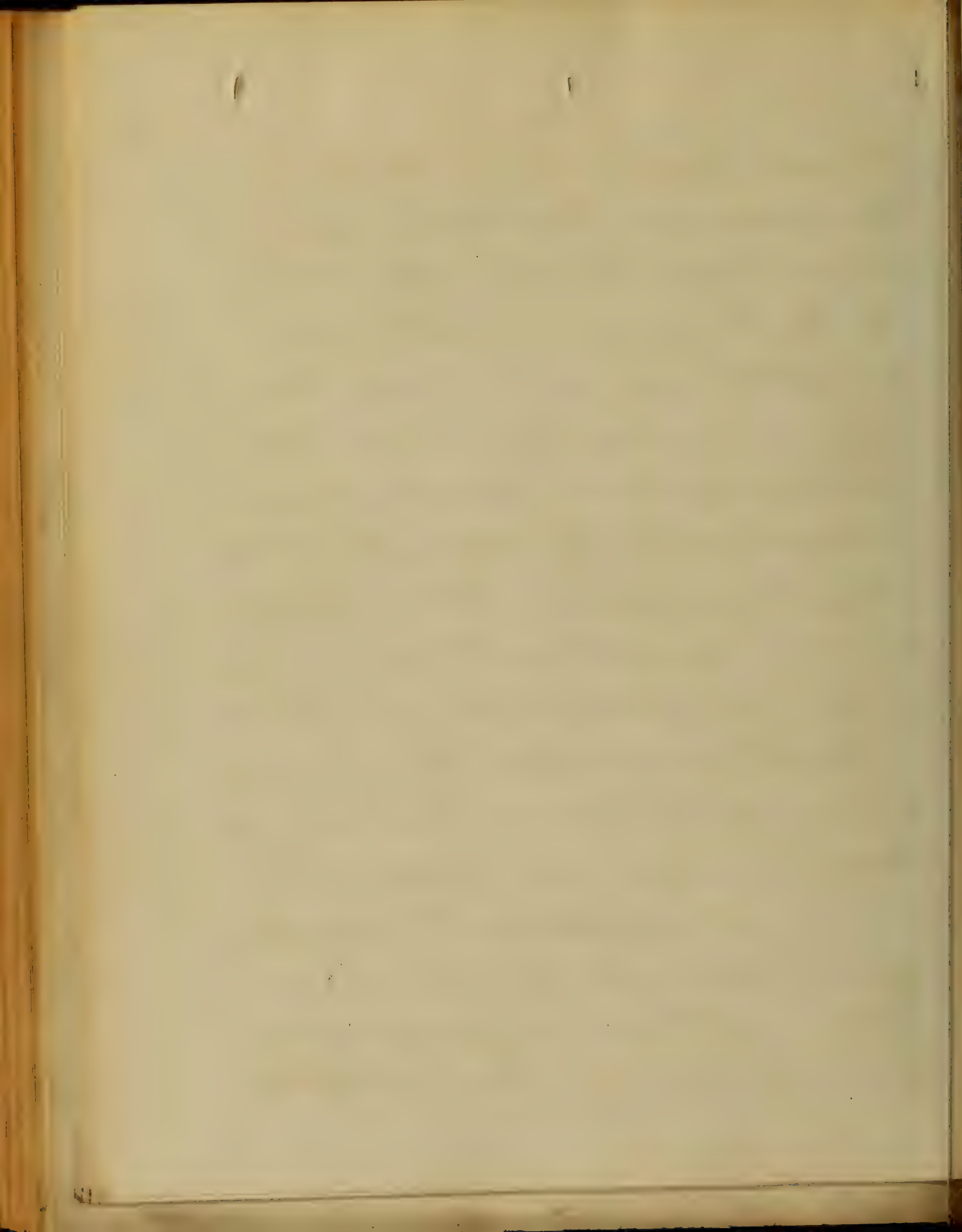


Malarial influences will modify the symptoms of pneumonia. This is a very common complication in malarial districts. The patients will complain of a dull aching pain in the back and limbs. They also have exacerbations of fever, and derangement of the function of the liver. Pneumonia sometimes assumes a typhoid character. There will be drowsiness, low, muttering delirium, and feeble pulse, with a tendency to extreme depression or diminution of all the vital powers of the organism. This form is known as the typhoid pneumonia. But there is a distinction to be made between typhoid-pneumonia and typhoid fever with pneumonia as a complication.



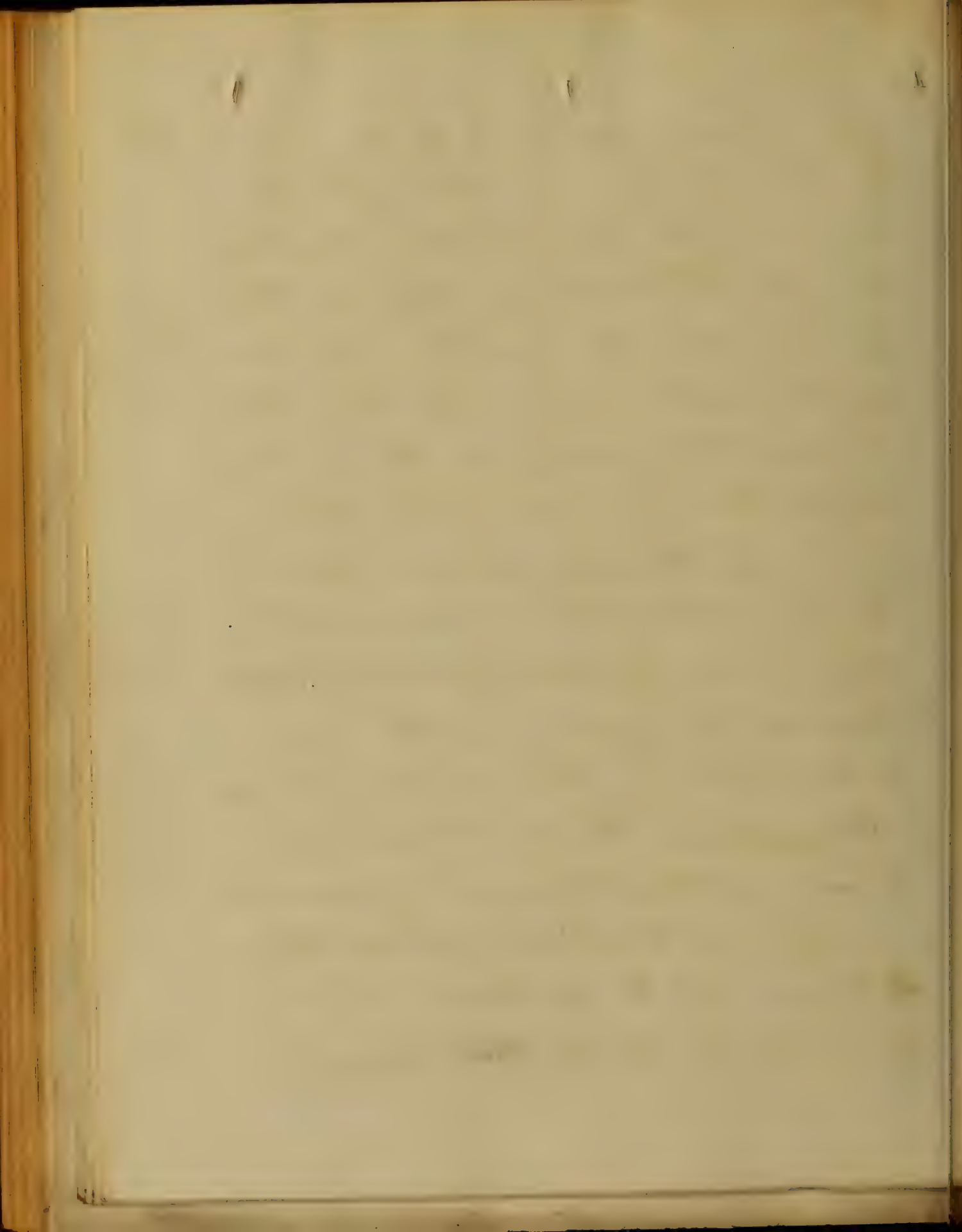
Physical Signs, In the first stage, on percussion there will be slight dullness over the congested portion of the lung, By auscultation the crepitant rale will be heard, this rale is heard only in inspiration, is produced by the air separating the adherent walls of the vesicles, The sound it produces, resembles that of rubbing a lock of hair between the thumb and fingers &c, It indicates congestion of lung tissue,

In the second stage there is decided dullness on percussion, And increased vocal fremitus which may be readily ascertained by palpation, The crepitant rale disappears when the lung becomes solid, and tubular, or bronchial, respiration and loud, vocal resonance or bronchophony



will be heard. Caused by the air in the larger bronchial tubes after the closure of the vesicles by the inflammatory deposit. In the third stage, or that of resolution, the exudation is removed by absorption, and expectoration, As resolution progresses the bronchial respiration is succeeded by the sub-crepitant rale; and sometimes the crepitant rale is heard in this stage also. Gradually all the abnormal sounds disappear and the signs of convalescence present themselves.

Causation. The most common cause of Acute Croupous pneumonia is exposure to cold or wet weather, Extreme high temperature in summer renders the system more susceptible



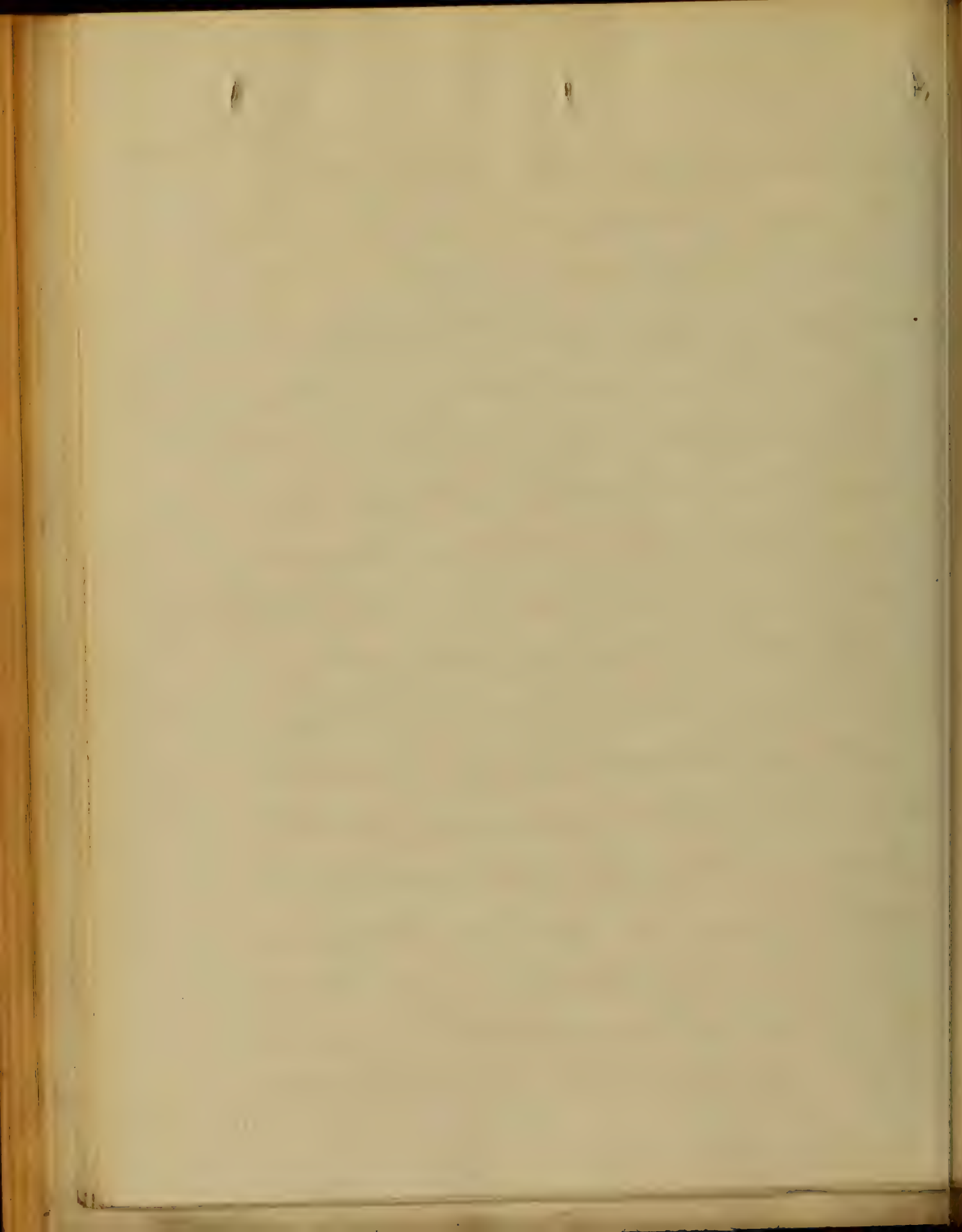
to attacks of pneumonia in extreme cold weather, It occurs much more frequently in winter, than it does in summer, It is liable to occur at any period of life, And oftener among males than females.

Diagnosis. When the patient is taken with a chill. succeeded by high fever, hurried respiration, increased frequency of the pulse, and acute pain in the side, with slight dulness on percussion, rusty sputa, and crepitant rale, the diagnosis can be made positively, But as these symptoms, and signs, are not uniformly present, pneumonia is liable to be confounded with other acute inflammatory diseases of the chest in the first stage, though after the

disease passes into the second stage the differential diagnosis may be made without difficulty by the aid of the physical signs. When the lung becomes solidified we will have decided dulness on percussion - bronchial respiration, and bronchophony, with increased vocal fremitus. With these phenomena we may exclude ordinary bronchitis,

In pleurisy we may have dulness on percussion, caused by liquid effusion in the pleural cavity, but the line of dulness can be changed, by changing the patient from a sitting, to a recumbent, position which cannot be done in pneumonia

In pleurisy, if there be a sufficient quantity of effusion to cause bronchial respiration and bronchophony, there will, also be bulging

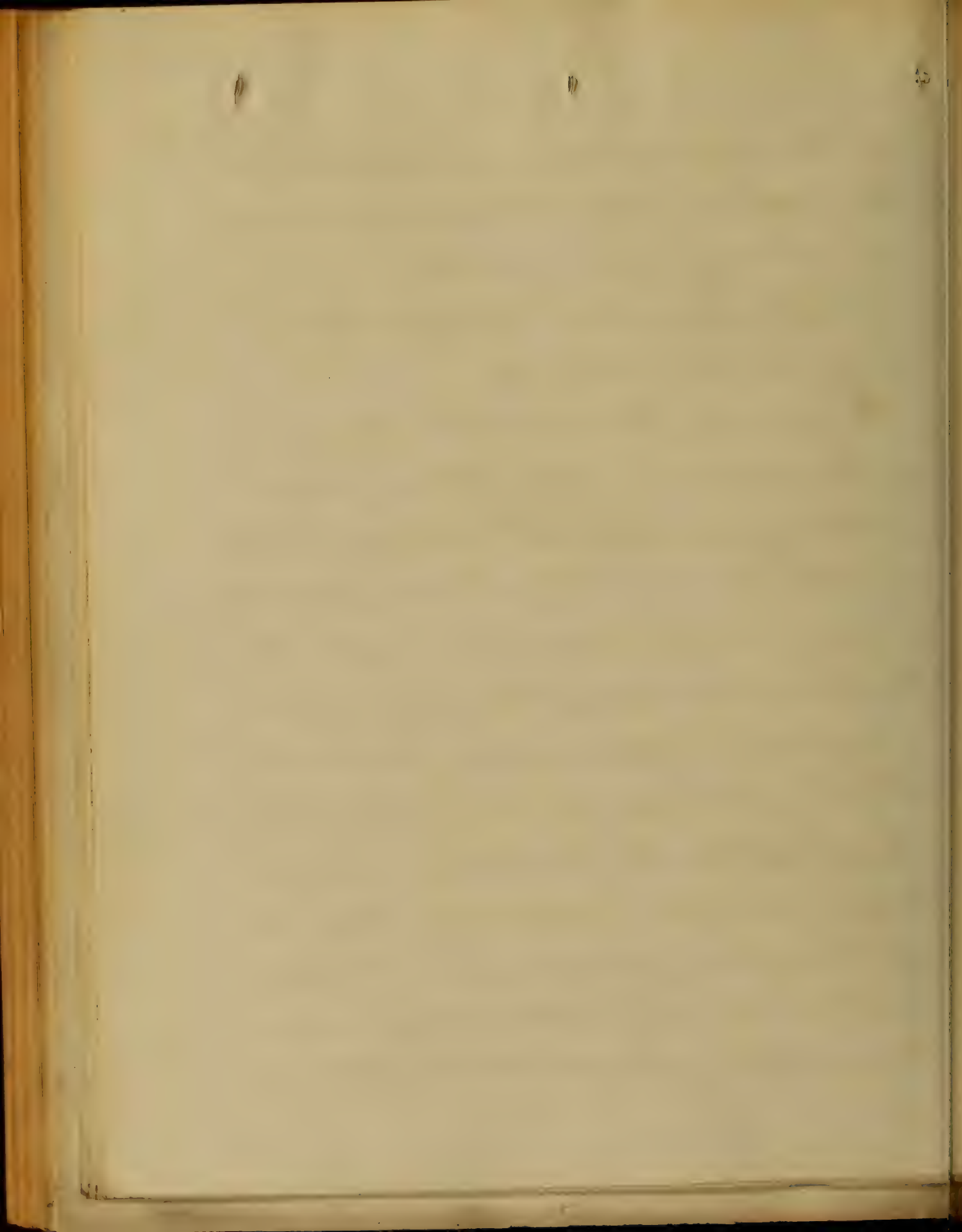


of the side, and diminution of the intercostal spaces, which will not be seen in pneumonia.

In pleurisy vocal fremitus is very feeble, in pneumonia vocal fremitus is very much increased.

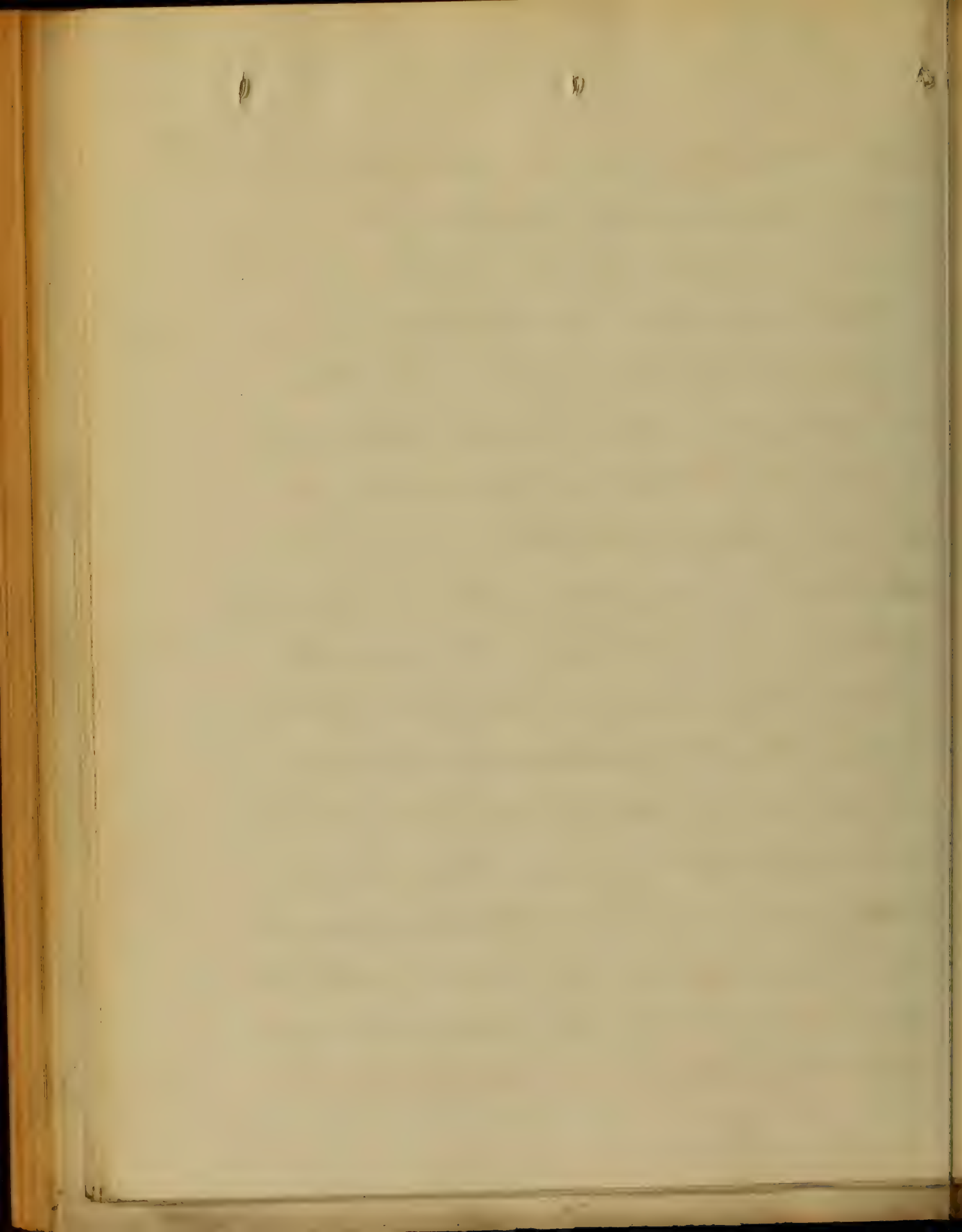
Prognosis. Uncomplicated pneumonia in persons previously healthy and vigorous is always favorable, the tendency being to pass through all the stages to recovery. In double pneumonia the prognosis is less favorable, though not necessarily fatal. In persons addicted to the excessive use of alcoholic stimulants the prognosis is unfavorable.

Treatment. In the first stage of acute croupous pneumonia, large doses of the Sulphate of Quinine should be given to act as an antipyretic. It may be given to an adult, in doses, from ten, fifteen, or

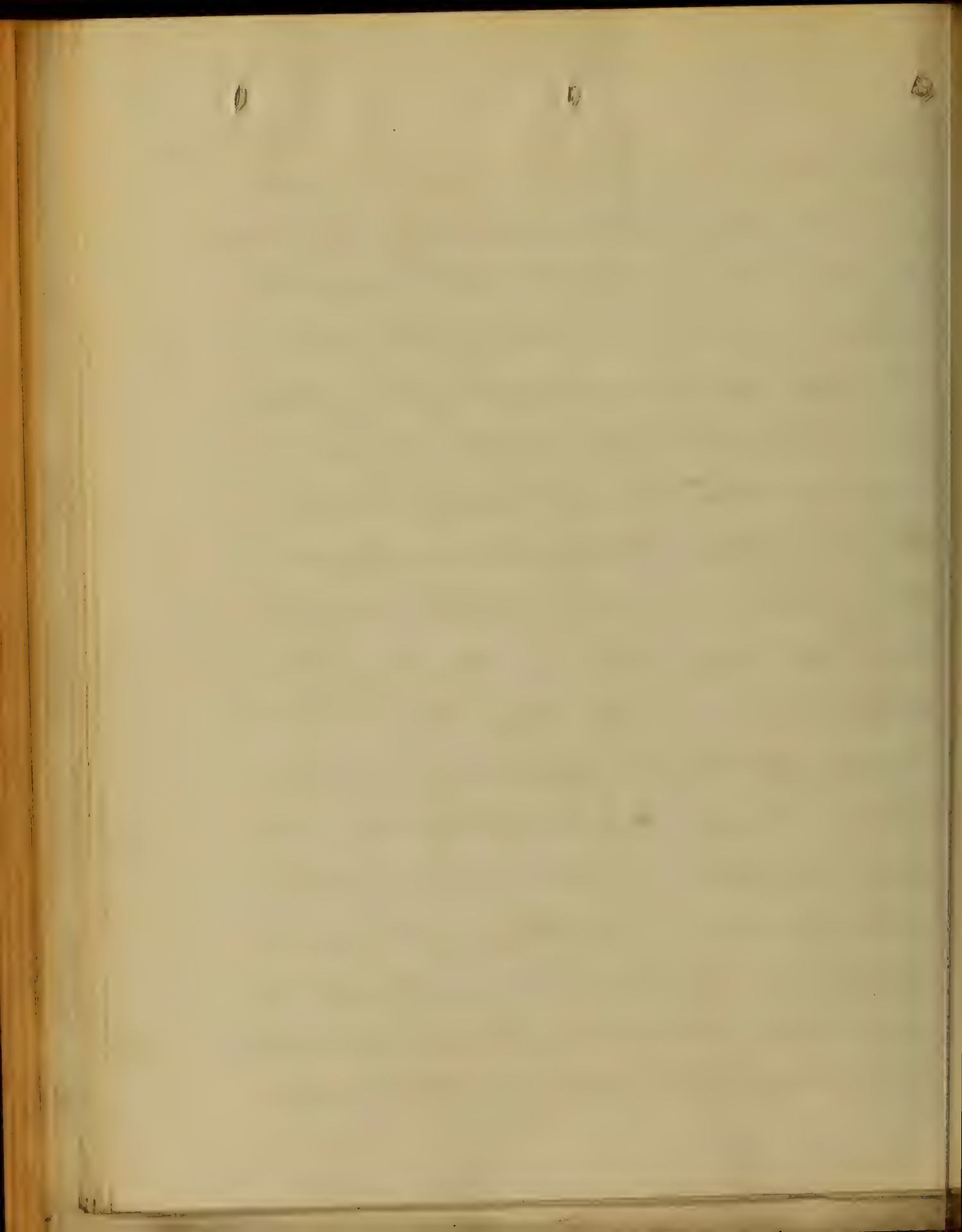


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even to twenty grains. In a child three or four years of age four or five grains may be given at a dose, if the bowels be constipated a saline aperient should be given for this purpose one or two drachms of the Rochelle Salt. or two to four ounces of the *Liquor. Magnesi. Citratis.* may be given. but care must be taken not to purge, Opium should be given freely in the first stage, with a view to relieve pain, tranquillize the system, and to diminish inflammatory action, it may be given in the pulverized form, from half a grain to two grains at a dose or the Sulphate of Morphia may be given hypodermically, from one eighth to a fourth of a grain at a time, either in the arm or immediately over the seat of pain.

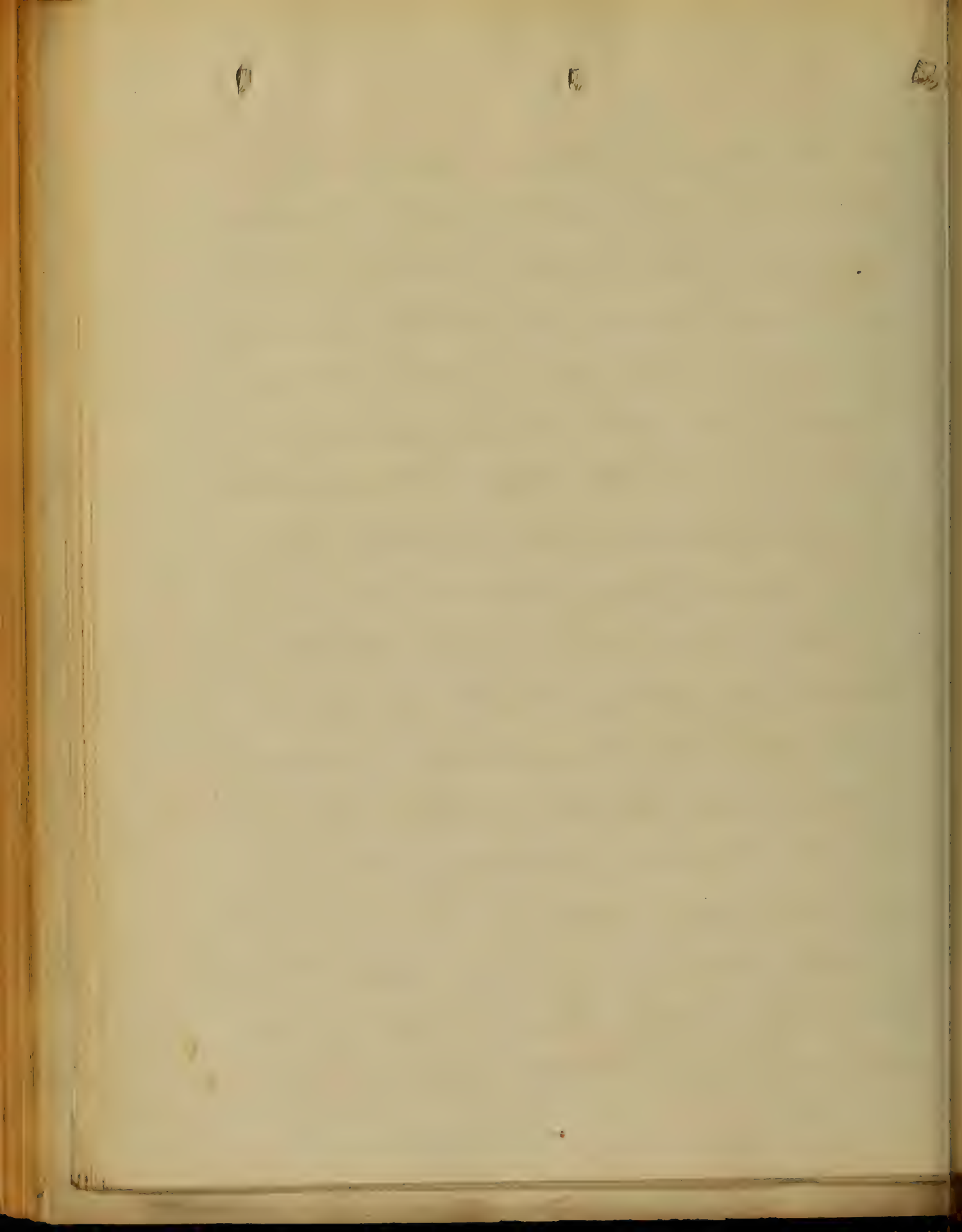


For the purpose of relieving Pain Warm poultices may be applied to the chest. They should be covered over with oil silk. Turpentine Stupes may also be employed with good results Dry Cups applied over the seat of pain will often give relief. When there is marked cardiac excitement, the Tincture of Veratrum Viride, or the Tincture of Aconite Root, may be given to sedate the heart's action, and to diminish the overflow of blood to the lungs. Either of these preparations may be given in the dose of one or two drops. If there be dyspnea or great embarrassment of breathing, due to an accumulation of blood in the right side of the heart. Blood letting will do good by relieving the venous congestion. In this condition the blood is taken from the patient with a view of giving relief mechanically.



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In the second stage of Acute pneumonia
The process of resolution may be hastened
by the use of the Iodide of Potassa. given
in the dose from five to ten grains.
For the same purpose the Compound
Tincture of Iodine may be applied
externally. In this stage, strict attention
should be given to Alimentation. The
most nutritious diet should be given
in fluid form, such as Milk,
Broths, and beef-tea. If there be a
soft, full, pulse, indicative of a tendency
to prostration, alcoholic stimulants
should be given in doses, such
as necessities require. The Carbonate
of ammonia is a good supporting
remedy in this stage of the disease
As a tonic the Compound Tincture of



Cinchona. or small doses of the
 sulphate of Quinine may be given
 And finally the observance of good
 hygienic rules should be insisted upon
 during convalescence —

Yours with great respect

John B. Butler

Finksburg

Carroll Co.

Md

An Essay on Diphtheria.

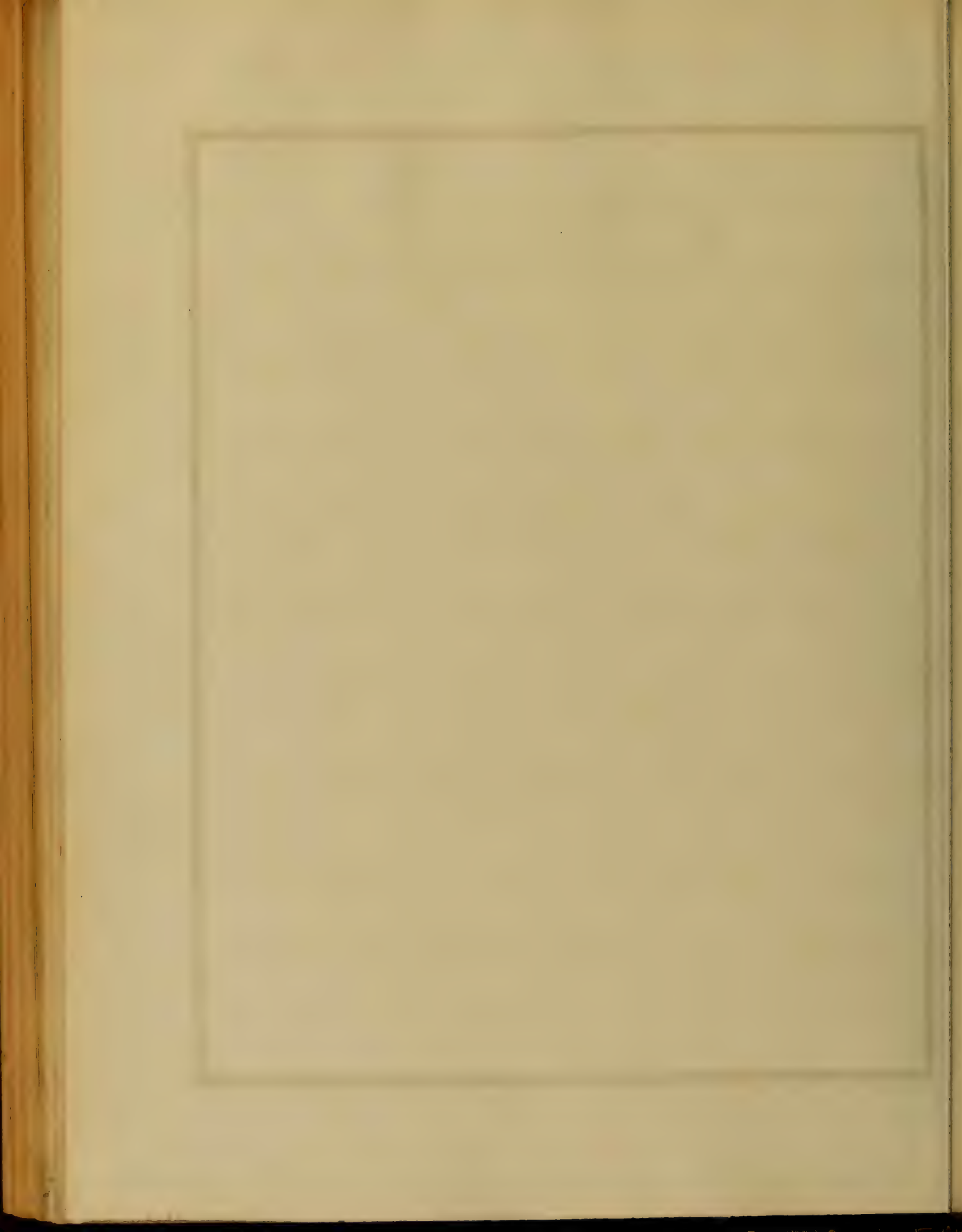
Respectfully submitted to the Dean of the
Medical Department of the University of
Maryland as a Thesis for graduation
February 1877, by L. C. Gordon.



Diphtheria.

In compliance with a rule of the University of Maryland, requiring a candidate for graduation to write a Thesis upon some medical subject, I have chosen the one which heads this page; and, although, from a want of practical experience I shall have to rely upon the opinions of others, I hope that I may be able to show some theoretical knowledge of the disease upon which I propose to write, and that my humble efforts will meet with the kind consideration of our worthy Dean and the gentlemen composing the Faculty.

Of all the constitutional diseases, exclusive of the essential fevers, one of the most important is Diphtheria. It has prevailed in various parts of the World, as an epidemic, from remote antiquity, and has from



time to time ^{been} described by different writers under various names, such as, *Morbus Egyptiacus* vel *Syriacus*, *Cynanche Maligna*, *Angina Maligna*, *Angina Gangrenosa*, *Morbus Suffocans* vel *Strangulatorius*, *Scarlatina*, *Malignant Sore Throat*, *Epidemic Croup* &c. It was described by Bard in 1789 under the name of *Angina Suffocativa*, and the distinctive features of the disease were pointed out by Bretonneau from 1821-26, who called it *Diphtherite*, the significance of which name relates to the formation of the false membrane.

Diphtheria is a blood disease characterized by local inflammatory manifestations. The inflammation occurs on mucous surfaces and is attended by fibrinous exudation and the formation of a false membrane. *Diphtheria* occurs in two forms, primary

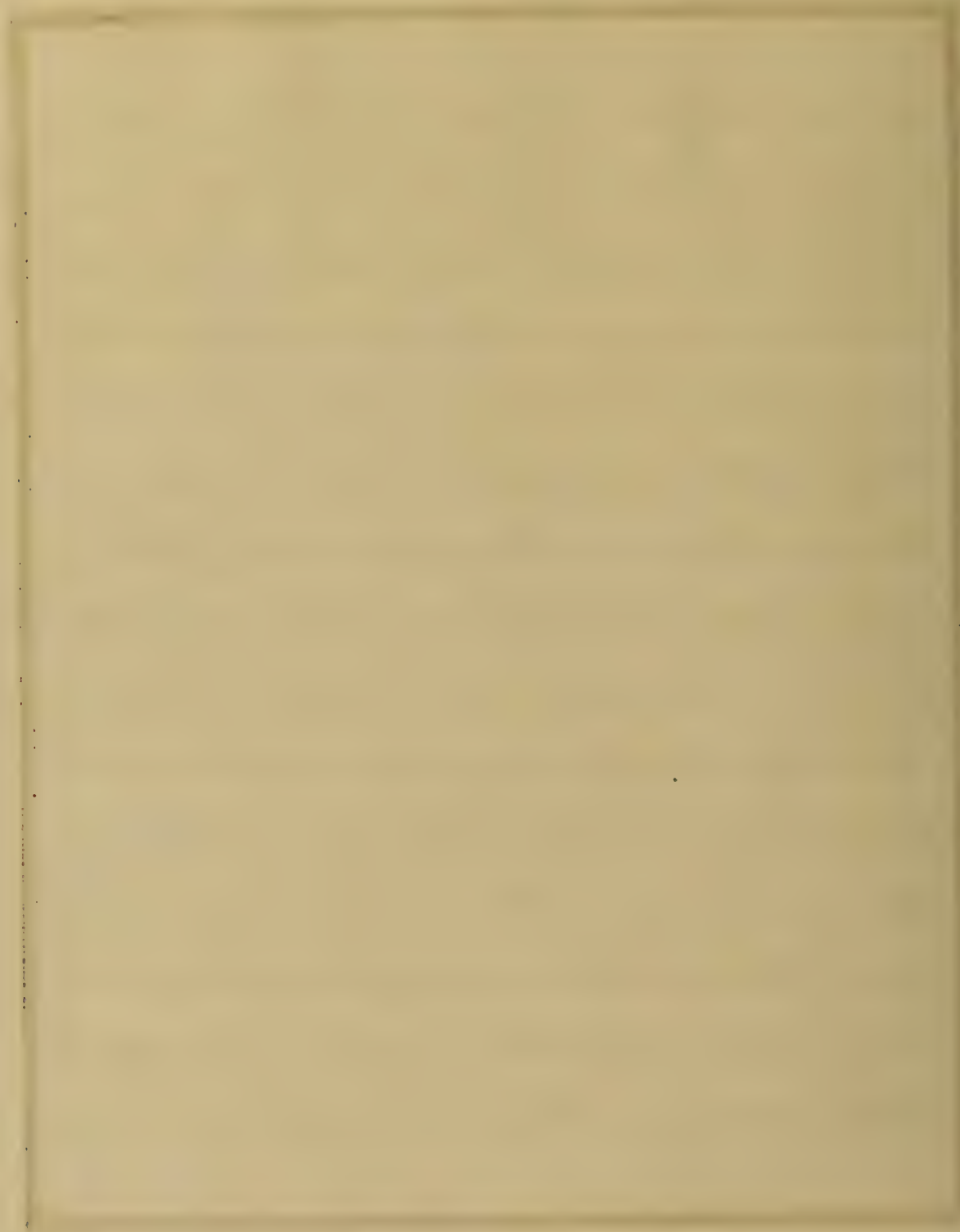


and secondary, the former is the more common, the latter is usually a concomitant of Scarlatina and Rubella; the two forms are identical in nature, and symptoms; but the secondary is generally a graver affection and is more likely to prove fatal.

Anatomical Characters. The characteristic feature is the false membrane. The fauces usually are first affected, and sometimes the affection extends no further. The first appearance is redness of the fauces with swelling of one or both tonsils. The pseudo membrane is at first thin and transparent, but soon becomes thick and opaque; it is at first white, but may become dark, either from decomposition, from the medicines given and from various other causes. It may extend over the posterior part of the pharynx, the palatine arches



the uvula and forwards over a greater part of the soft
palate; in fact, no mucous surface is exempt from a
liability to be attacked, for it not infrequently extends
to the posterior nares and larynx, occasionally to the
bronchial tubes, oesophagus and stomach, and more
rarely to the conjunctiva, anus, vagina and Eustachian
tubes, and may even attack the skin itself when it
has been excoriated. When it extends beyond the fauces
it is not to be considered as spreading by continuity,
but as a distinct local manifestation of a constitu-
tional affection. The lymphatic glands of the neck,
especially those behind the angle of the jaw, are liable
to swell during the course of the disease, thus giving
rise to Cervical Adenitis; but they rarely suppurate.
The false membrane, if allowed to prolong, is thrown off



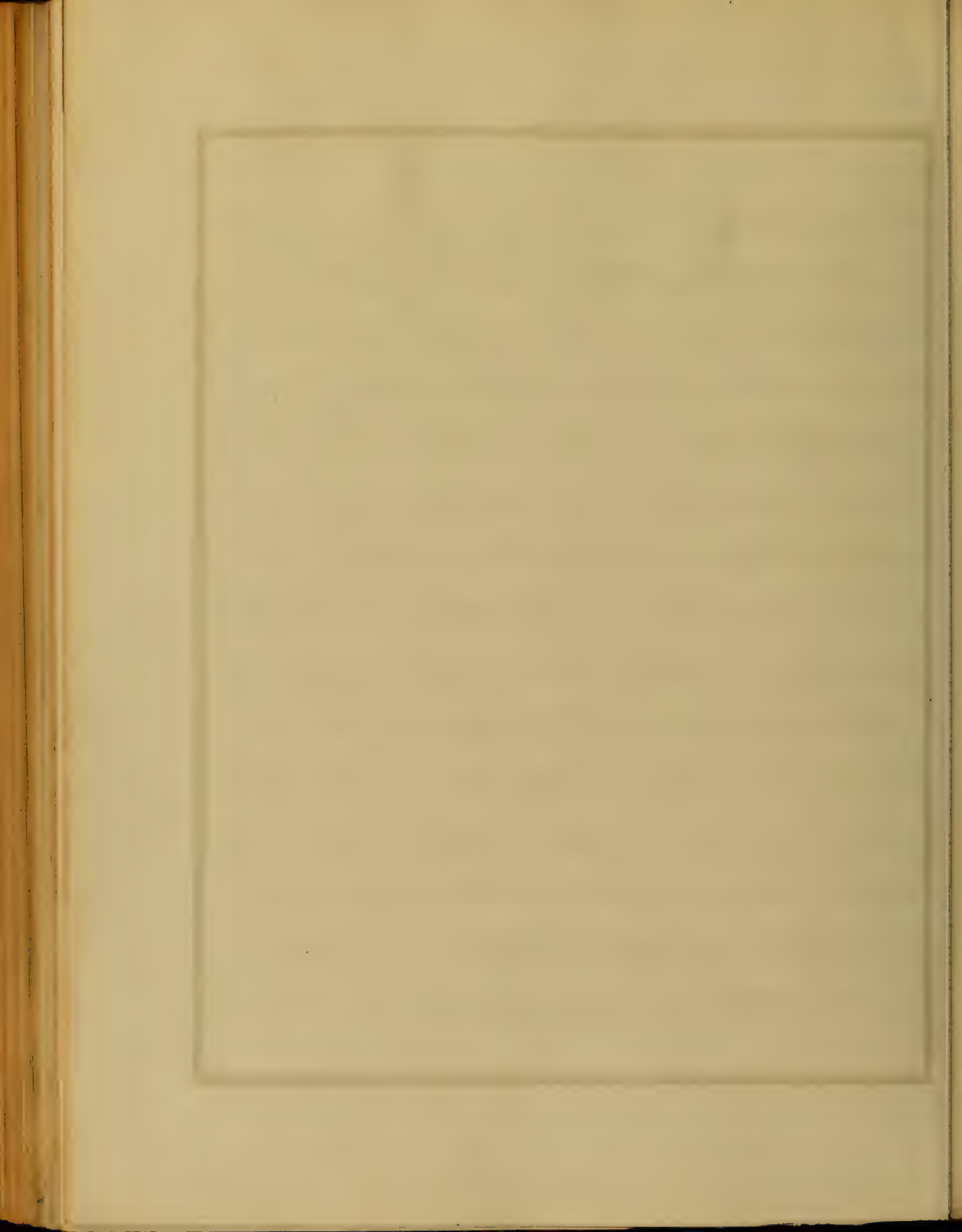
by a process of ulceration in from three to twenty days; it is not infrequently followed by a second, third or even a fourth one. Pathological Histologists have lately made a distinction between the false membrane of Diphtheria and that of True Croup, the former they claim consists of cellular elements, and not of fibrin and lymph. These cellular elements they regard as modified epithelial cells, and that after the separation of the false membrane there is left an ulcerated surface: while in True Croup the false membrane consists, in part at least, of fibrin and lymph, and after its separation there is found to be no loss of substance. After death from Diphtheria the blood is found to be dark colored, due in part to want of oxygenation in those in whom the disease extended to the larynx, and in part to the malignant



Character of the disease. The heart clots are soft. There are no morbid conditions of any internal organs found after death, due to the disease itself.

Clinical History. The disease may be ushered in by a chill followed by a severe fever, but its most usual mode of onset is by a general feeling of malaise for some days, the condition of the throat being only discovered when examined. The formation of the membrane in the fauces is rarely attended by pain, in fact, there may be diminished sensibility or an entire loss of it in that situation. Deglutition may be painful but is not generally so. The patient during this stage has a paresis of the muscles of deglutition, giving rise to difficulty in swallowing, and on attempting to swallow liquids they may be regurgitated through

the nose. If the membrane extends over a greater part of the mouth it will give rise to pain in swallowing, stiffness of the jaws and fetidism. The breath is often fetid as if gangrene had taken place in the throat or lungs, but the latter affection does not often ensue. If the disease extends to the anterior nares it is accompanied by a discharge which occasions irritation and excoriation of the upper lip corresponding to the nostril affected. If it extends to the larynx we have many of the symptoms of True Croup, viz; cough, dyspnoea and aphonia. Embarrassment of respiration out of proportion to the affection of the larynx points to its extension to the bronchial tubes. I will now take up the symptoms referable to the different systems, as follows; the circulatory, respiratory, cutaneous



digestive and nervous. The pulse may be either greatly or little accelerated, it may even fall below the normal standard, it is soft denoting diminished heart power; it may be irregular denoting gravity, when the irregularity does not depend upon an organic disease of the heart. Hemorrhage may take place from the nose, throat or mouth, and when profuse is an unfavorable sign. The symptoms due to the respiratory system occur when the disease extends to the larynx or bronchial tubes, and if life is prolonged the false membrane is thrown off by expectoration. The skin does not present much increase of heat and the thermometer shows the temperature of the body to be not much if any above the normal standard. There may be feet chills; the skin may

be livid when the disease has extended to the air passages.
The desire for food is generally lost and there may be vomiting.
Diarrhoea sometimes occurs. The false membrane may be
vomited if the disease has extended to the oesophagus or
stomach. Albuminuria may occur, usually in small
quantity; it is generally in proportion to the gravity
of the local symptoms. Haematuria may occur.
General dropsy is rare. An increased amount of
Urea may be found in the urine showing an increased
waste of tissue. Delirium is rare, but it may occur,
either passive or active, when the latter it denotes
gravity. Convulsions are rare as also is coma, and
if the latter occurs it is due to uraemia and usually
denotes a fatal termination. The usual duration
of the disease is from one to two weeks, although, death

may occur in forty, eight hours; or it may be prolonged to an indefinite period, owing to complications with other diseases. The most prominent sequelae are anaemia, feebleness of the heart's action and functional paralysis of both voluntary and involuntary muscles. The paralysis generally attacks first the soft palate giving rise to difficulty in deglutition; it generally occurs in from one to four weeks after convalescence has set in, although, it may occur during the career of the disease. It may affect the tongue and muscles of the face giving rise to difficulty in speaking. When it extends further it generally attacks the lower extremities first, then the upper, or we may have hemiplegia or paraplegia, or one upper and the opposite lower extremity may be affected.



It may be either complete or partial and may be attended with either loss or exalted sensibility. The external rectus muscle of the eye is sometimes paralyzed giving rise to converging strabismus, or Amaurosis may occur, attributable most probably to Uraemia. The paralysis may affect the intercostal muscles and the diaphragm, giving rise to dyspnoea; or the sphincters, causing retention of or inability to hold either the feces or urine. The paralysis whatever part it attacks is purely functional and no cause has been found for its production. It usually disappears as the patient regains his strength and in general has entirely disappeared in a few weeks or months.

Pathological Characters. Diphtheria is a Constitutional



disease and the local manifestations depend upon the constitutional disturbance. It is supposed by some to be identical with Pseudo-membranous Laryngitis, but besides the difference in the composition of the false membrane, pointed out by Rindfleisch and others, there are other points of dissimilarity, among which are that the inflammation in True Croup commences in the larynx and does not extend to the nose and oesophagus; in Diphtheria it begins in the pharynx: in the former the affection is spasmodic; in the latter the onset is more gradual and generally occurs as an epidemic. The enlargement of the cervical glands is greater in Diphtheria. Albuminuria is not frequent in Croup and Paralysis is not a sequel.



Diphtheria generally occurs in children, Diphtheria is liable to occur at any age and may prove fatal without extending to the larynx. Diphtheria has also been confounded with Scarlatina, the points of difference are that in Scarlatina there is the characteristic eruption, the inflammation is not liable to extend to the larynx, and a person usually has the disease but once, while in Diphtheria there is no characteristic eruption, the disease may extend to the larynx and a person may have it several times. The characteristic sequels of Scarlatina are dropsy and Albuminuria, which rarely follow Diphtheria; the most common sequel of Diphtheria is paralysis, which rarely follows Scarlatina. Some authors believe that Septicaemia may be caused by the resorption of the exudation in Diphtheria, if so, the best plan would be to effect the



separation of the false membrane as soon as possible; but others assert that it is more rational to attribute the constitutional symptoms to the morbid conditions which constitute the disease.

Causation. Diphtheria almost always occurs as an epidemic, although sporadic cases have been known to occur; and, like other epidemic diseases is believed to be due to a special virus. There is a difference of opinion as to whether or not it is infectious, but most authors believe it to be contagious. Circumstances relating to occupation, social position &c., seem to have nothing to do with its causation, although, in epidemics of the disease those who live in crowded, damp and ill ventilated tenement-houses, are more liable to be attacked, than those who observe temperance.



Hygienic laws. A mild form of the disease may communicate a severe one and vice versa. The ages most liable to it are from 7-15 years, although, it may be contracted at any age. Dr J. Lewis Smith says he has seen a case at three months, and Daviot reports one case in a person over fifty years of age. In Daviot's report females seem to be more liable to it than males. Different epidemics differ as regards the character of the disease; in some there is a great liability of its extension to the lungs, and in others it rarely extends beyond the lungs. The period of incubation is from two to seven days. There was no epidemic of it in this country from 1771 to 1806, since which time it has been prevalent occasionally in some part of the country.

Diagnosis. Different cases differ so in regard to the



premonitory symptoms that the diagnosis is scarcely possible before the false membrane has been formed. In some cases only slight or any constitutional symptoms are observed, in others there is great derangement of the system. A case is to be diagnosed by the prevalence of the disease as an epidemic, and by the formation of the false membrane, and it can scarcely be confounded with True Croup if I mention in mind the points of difference already designated. Many practitioners confound cases of Pharyngitis with Diphtheria and to hear them talk, one would be led to believe as they do themselves, that Diphtheria was a very common disease, on the contrary, it is not a common disease. The disease is only to be called Diphtheria when the false membrane has been formed. Ordinary Sore throat



because to a great extent in epidemics of Diphtheria, and is not to be confounded with it. The differential diagnosis between Diphtheria and Scarlatina has already been pointed out.

Prognosis. Different epidemics differ widely in the rate of mortality. The difference in the statistics is due, in part, to the mildness or severity of the epidemic, and, in part, to the habit some physicians have of including in their reports cases of Follicular Pharyngitis. The greatest danger is from an invasion of the larynx, when that occurs the prognosis is very unfavorable. When the larynx is attacked death generally results from asphyxia. The next great danger is from exhaustion of the vital powers; the disease has been known to destroy life within forty-eight hours, but generally there is a gradual

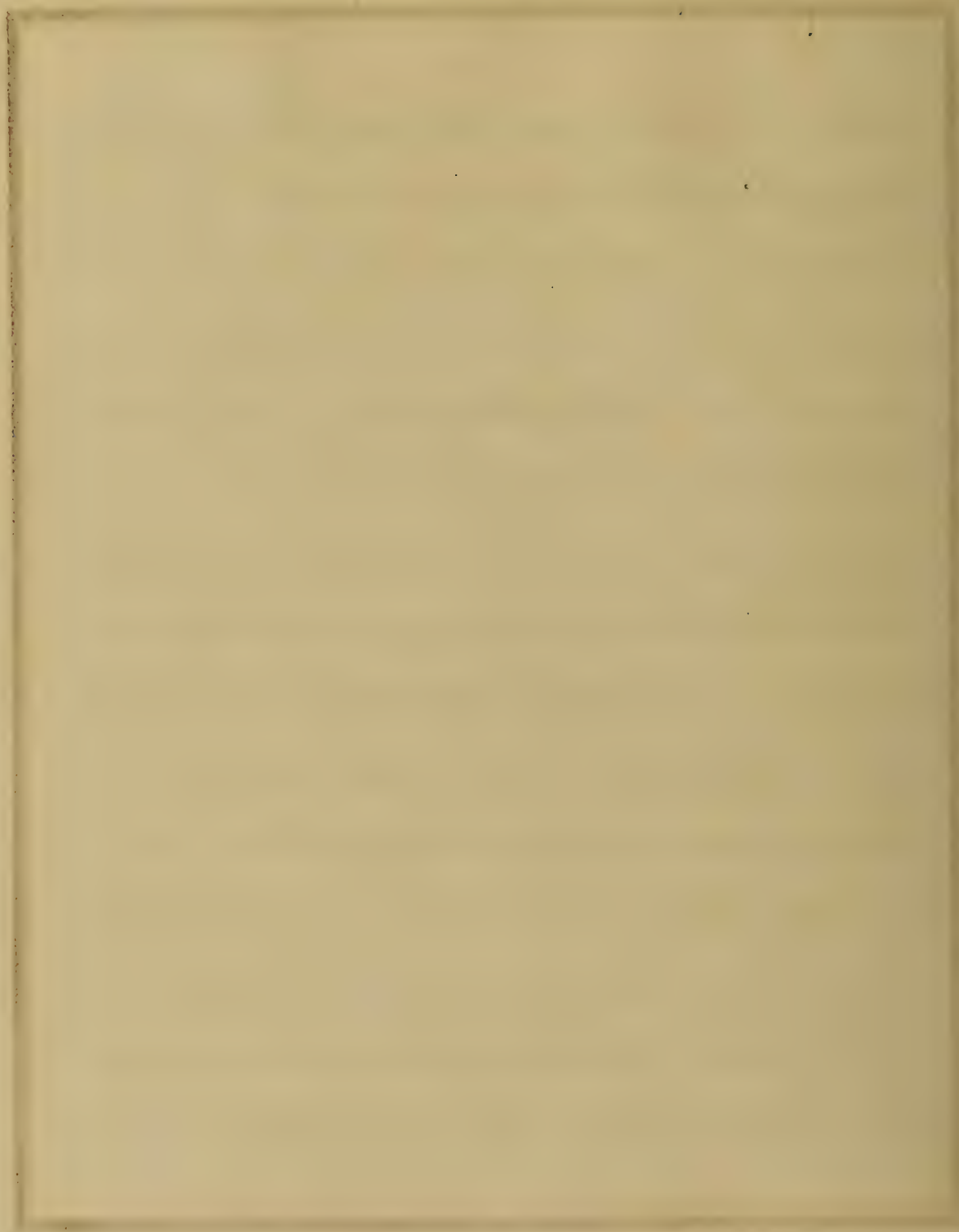
decline of the vital powers and death finally occurs. When the larynx is unaffected, the prognosis is unfavorable when the disease extends to the anterior or posterior nares or when it spreads widely in any direction. Other unfavorable symptoms are, ecchymosis or hemorrhage from any part, vomiting, diarrhoea, coldness of the skin, irregularity of the heart's action, abundance of albumen in urine, delirium, convulsions and coma. Dr. Meigs reports three cases of death from the formation of a thrombus in the right cavities of the heart, death taking place upon the patients attempting to get out of bed. The paralysis which usually follows Diphtheria is not generally serious unless it interferes with the muscles of deglutition and respiration.

Treatment. We now come to what may be considered, after the diagnosis, the most important thing to be

dwell upon, the treatment and, if possible the cure of the disease. The treatment may be divided into general and local. I will first take up the local treatment when the disease does not extend to the larynx. It was formerly the habit to apply caustics, such as the Nitrate of Silver, the Sulphate of Copper and the mineral acids, but such treatment has been generally discarded and in its place gargles, antiseptic and emollient preparations have been substituted, such as weak solutions of Nitrate of Silver and Chlorate of Potash. Ice may be taken into the mouth if agreeable to the patient, if there is fetor we may use weak solutions of Chloride of Sodium, the Iodide of Bromine, Carbolic or Salicylic acids or Creosote. The Sulphites have been recommended in this as in other zymotic,

diseases from their supposed power of preventing catalysis,
by Prof. Polli of Milan. He states that the Sulphurous
acid set free in the system by their decomposition
will prevent it. It is well known that they prevent
fermentation outside the system, but whether, as
Prof. Polli claims, they are of benefit in D. D. D. D. D. or
other zymotic diseases, is still a disputed question,
and, although, their use would do no harm, we have other
remedies, which until the question of their usefulness has
been settled, I think it would be just as well to use.

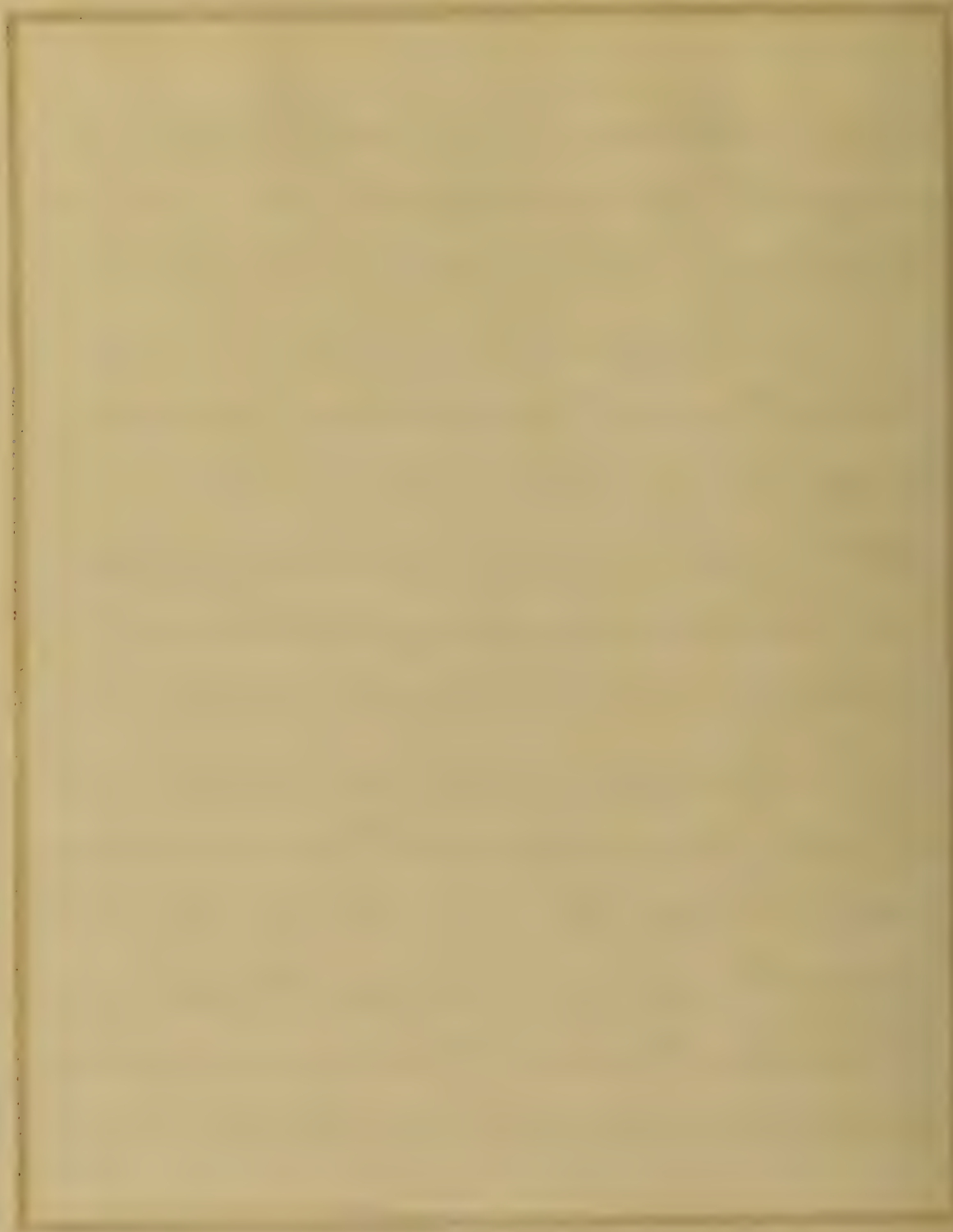
This recommends a gargle a half a drachm of the
Hyposulphite of Soda dissolved in half a pint of water.
When the patient is too young to gargle, the mixture
may be applied to the parts by means of a camel's hair
brush. When the disease includes the larynx the local



treatment is ~~the~~ same, but, we must in addition endeavor to separate the false membrane, the best means of doing which is by the inhalation of vapor or steam; sponging the throat with lime water, or slacking lime in the patient's room has also been recommended.

I will now consider the general or constitutional treatment. There is no specific remedy for the disease.

Diphtheria being a constitutional disease, and the danger depending to a great extent on death from exhaustion, the great indication for treatment, it seems to me, is to support the system by tonics, stimulants and nutritious food. The Sulphate of Quinia, Tincture of Iron and Chlorate of Potash are extensively used, the two latter may be given in combination. Alcohol



is useful when the pulse becomes weak and symptoms of exhaustion show themselves, and in some cases is tolerated to a great extent. The Permanganate of Potassa has been recommended, a drachm of the salt to a pint of water, a teaspoonful to be given every three hours. Alimentation is one of the most important parts of the treatment. The diet should be concentrated and nourishing. Milk is as good as anything you can give, beef tea, soups and other things may also be given. Ventilation is another thing that should be attended to in this disease. The patient should be placed if possible in a room with an open fire place, if not, the room should be thoroughly ventilated every day, without allowing the patient to be exposed to draughts. Incidental symptoms are to be treated as they arise vomiting.



may be checked by appropriate remedies, diarrhoea
by opiates or astringents, sleeplessness by either
opium or the bromides. If all the measures we
may employ do no good and the patient continues
to grow worse, there is only one question to decide,
shall or shall we not perform tracheotomy.
It is one of the most fatal operations in
surgery. Pouchet states that of 5740 operated
on 310 died; still it does sometimes save life,
and I think when we have done all we can
with medicine and have found that our efforts
have been unavailing, and that the patient
is sure to die unless we interfere, that it
would be doing wrong not to perform the
operation no matter how slight the chance

of recovery and even if it promised but to prolong
life for a little while; provided, of course, we have
previously obtained the consent of the patient
himself, or if a child of its friends

Some recommend operating as soon as the
false membrane has formed, others, and the
majority, I believe, not until signs of want of
oxygenation of the blood have set in.

With regard to the prevention of Diphtheria,
if a case occurs in a family, isolate it, and during
an epidemic, remove persons, especially children,
beyond its influence.

L. C. Gordon.



A.

Thesis

On Pneumonia

Submitted to the Examination

Of The

Provost Regents and Faculty

Of Physic of The

University of Maryland

For The Degree

of

Doctor of Medicine

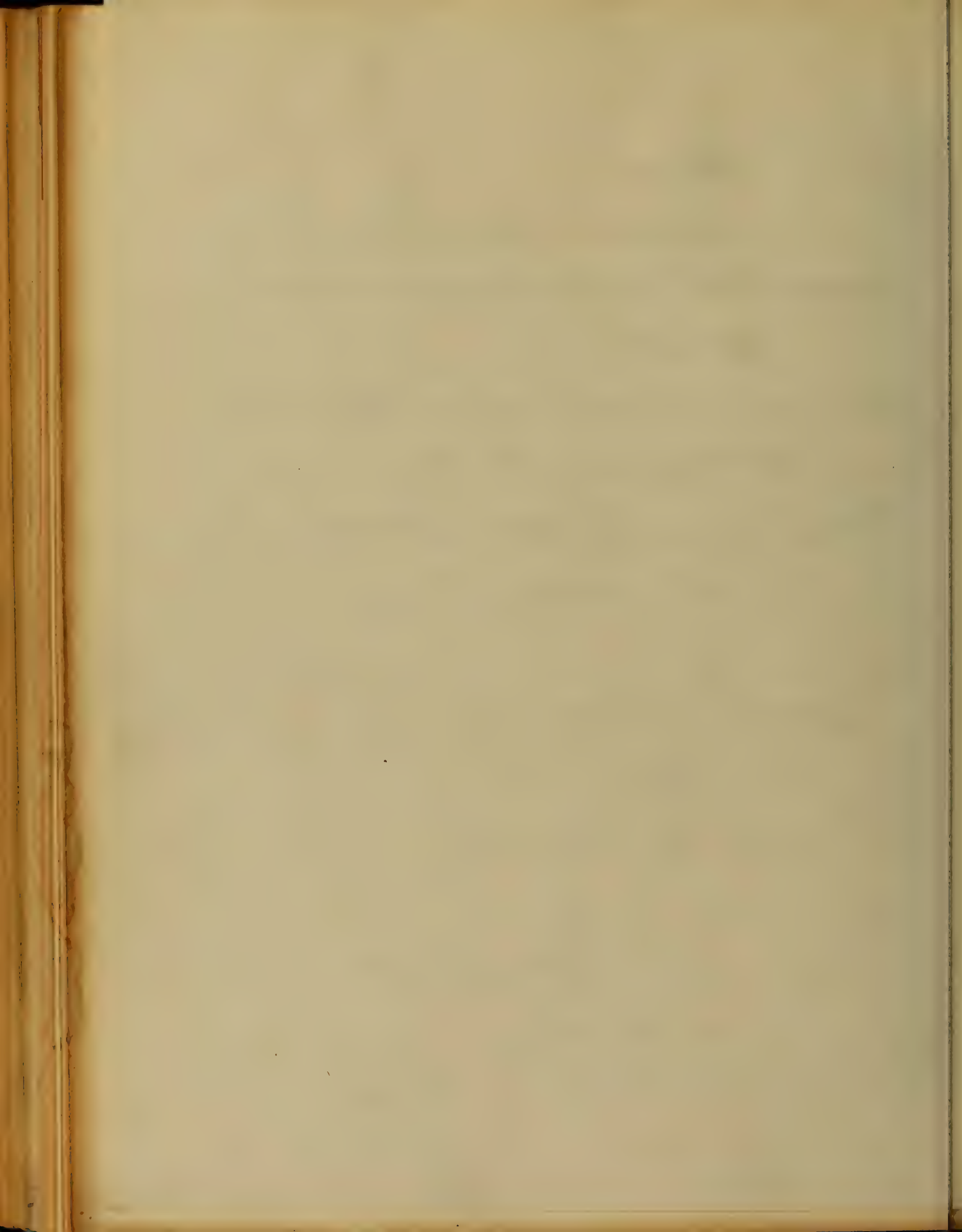
By

C. D. Laws

of

Virginia

A. D. 1877



Pneumonia

Is an inflammation seated in the pulmonary substance or parenchyma of the lungs

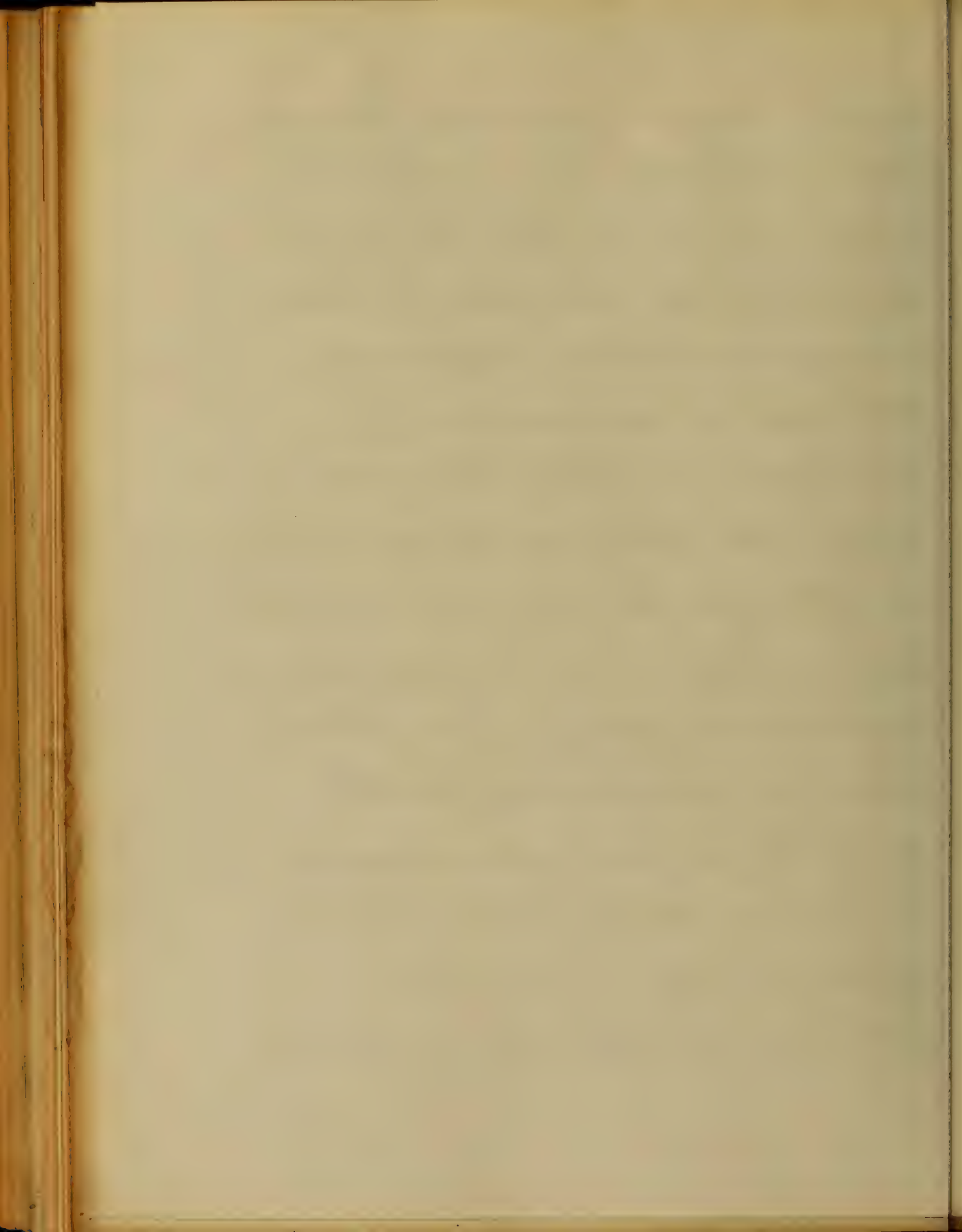
The membrane lining the air cells & bronchiales is distinguished from the membrane which lines the bronchial tubes by its tenacity by absence of mucous follicles & by a change of epithelium from the cylindrical & ciliated to the squamous variety

In acute pneumonia the membrane lining the air cells & bronchiales is inflamed

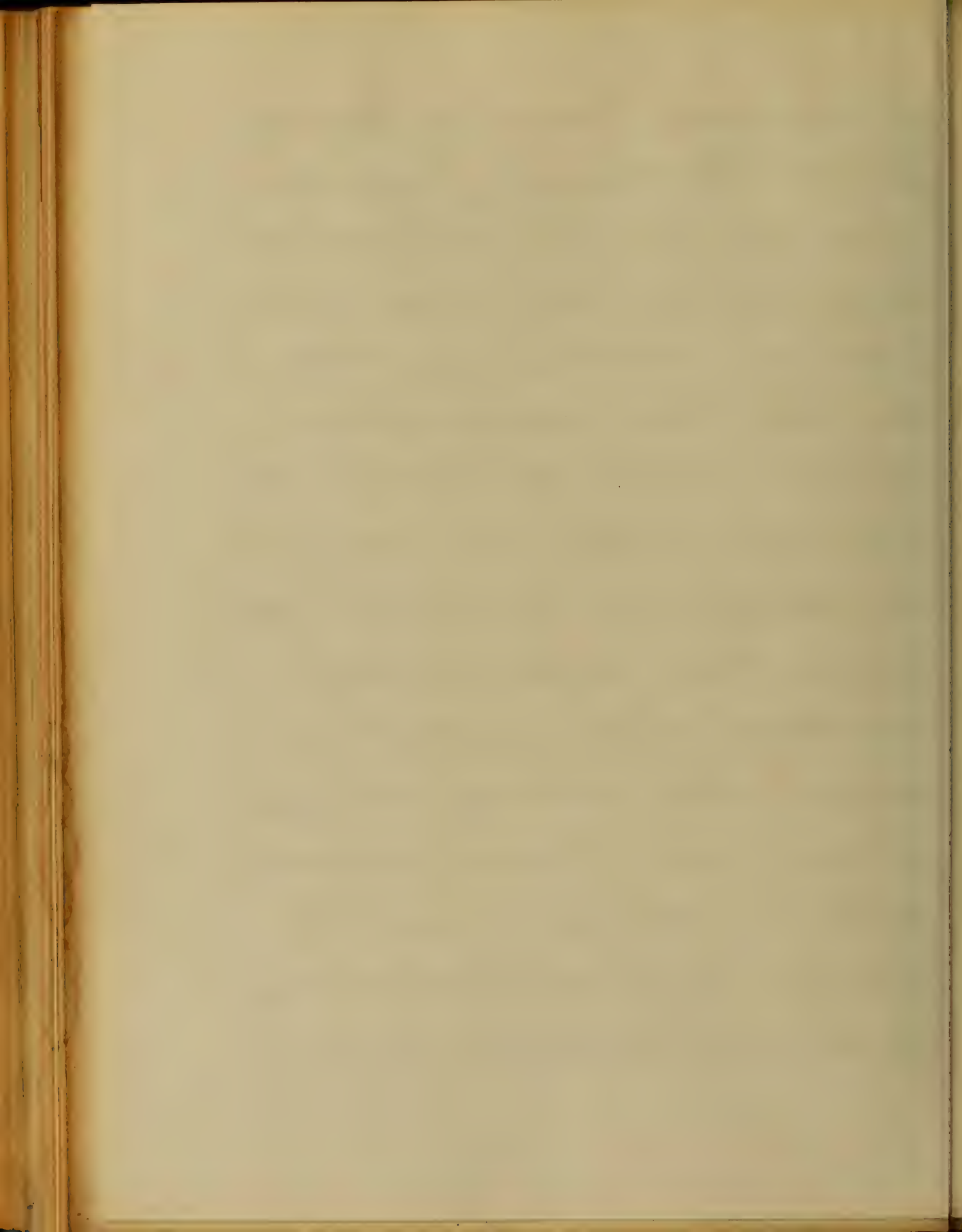
Varieties; according to Seat as

Single; double; lobular, according to causation as idiopathic from cold or wet; Traumatic from injury, Curious or Tuberculous in Psephosis or Typhoid
Anatomical characters,

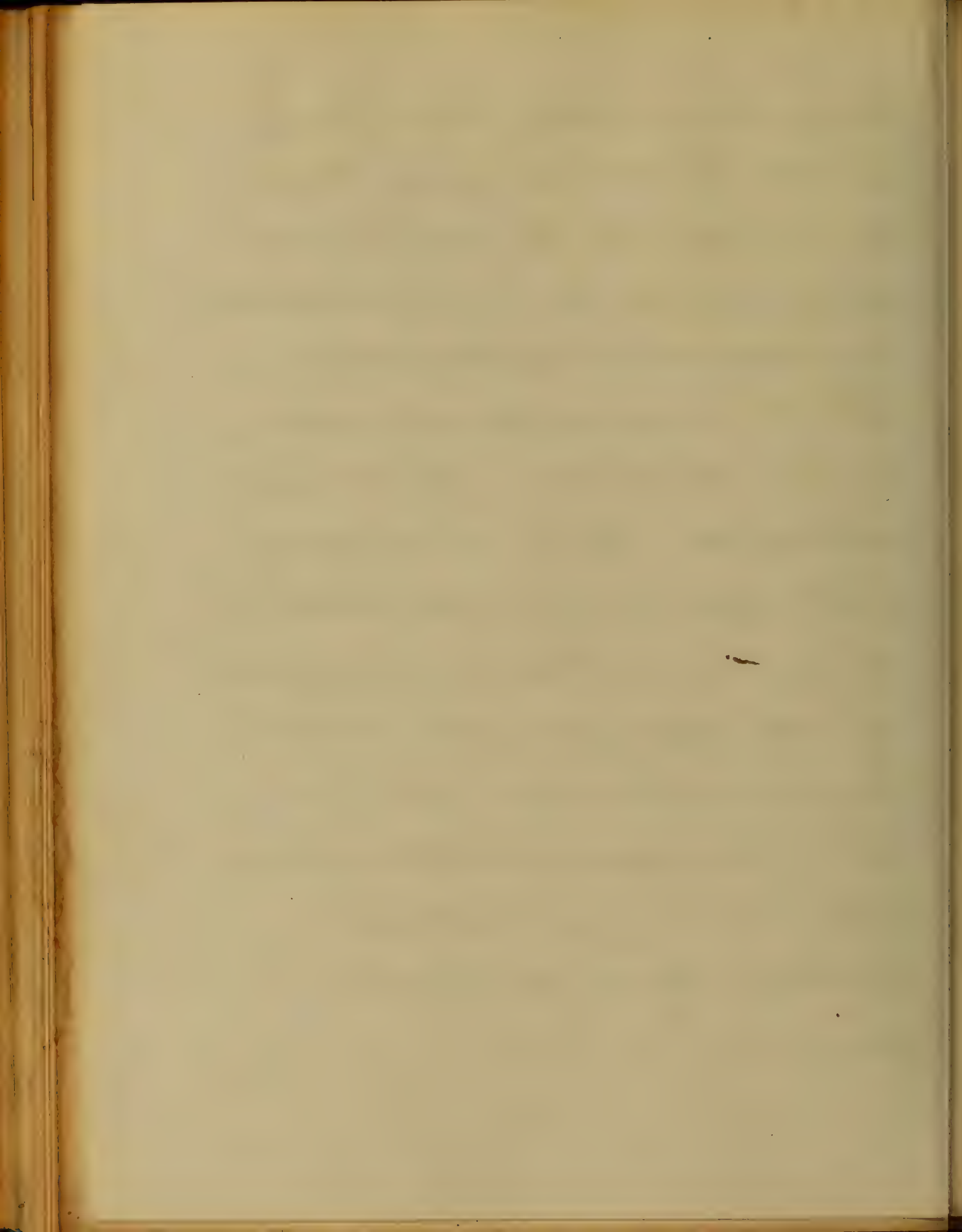
1st stage is a stage of engorgement; the inflamed lung is heavier than in its normal condition, The surfaces when cut present a dark appearance & blood flows in abundance; In the majority of cases this stage is 24 to 48 hours in duration
2nd stage or that of exudation



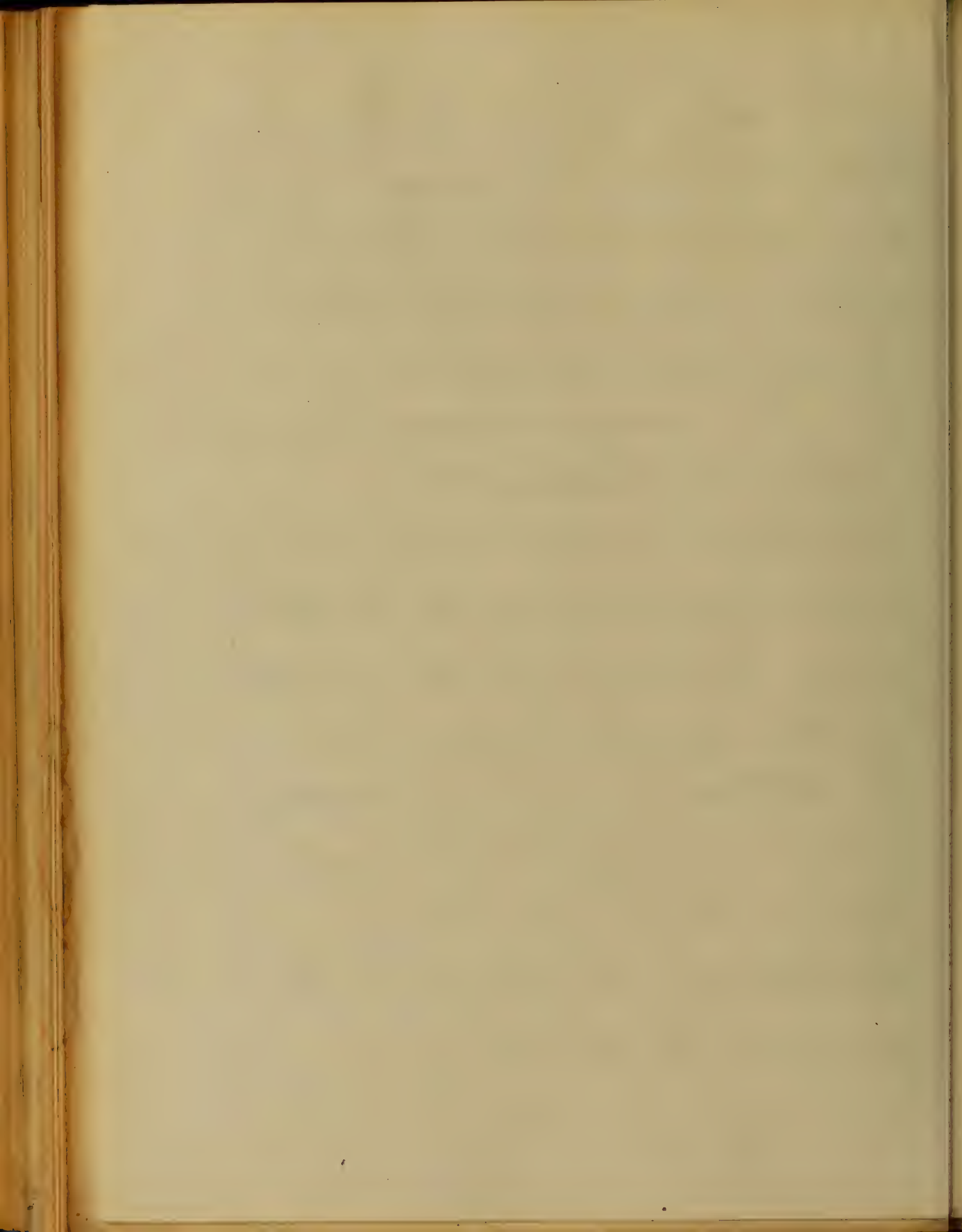
a coagulating material escapes
from the blood-vessels & coagulates
within the air cells; The cells cease
to contain air The lung is then
said to be hepatized; it contains
but little blood & presents an
anemic aspect, On section the
cut surfaces present a granu-
lar appearance, The lung is non-
flexible than in its normal
condition, it is increased in
weight & This increase of weight
is due to an amount of solid
matter withdrawn from the
blood Owing to absence of air
portions of the lung sink when



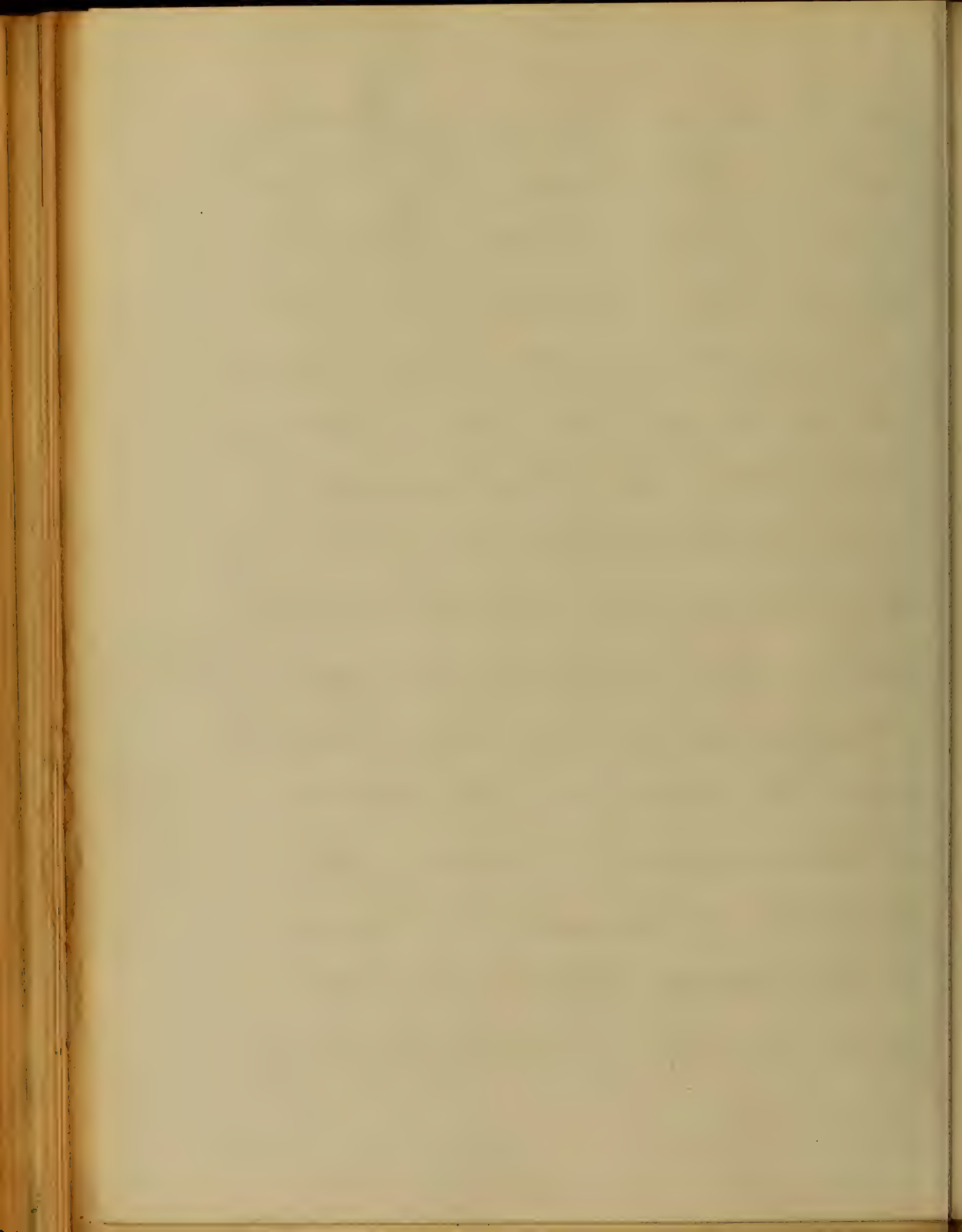
thrown into water; This stage usually continues from two to four days & if the case terminate favorably the exuded matter is removed by absorption & after its removal the air-cells are found to have sustained no damage, But if the progress of the disease be unfavorable the exuded matter is not absorbed & the affected lobe or lobes become infiltrated with fluid. The lung is gray in appearance & the substance is softened breaking down on slight pressure.



3rd stage. Gray hepatization
softening. The third stage consists
in degeneration (in absence
of more favorable resolution
by absorption) of the exudation
This occurs by granulation
softening & suppuration
occasionally an abscess forms
In gray hepatization the lung is
solid; impervious to air, with
a granite like appearance
on section, it sinks in water
& is more easily ^{crushed} into a pulp
than in the second stage
Symptoms; The attack is apt
to occur at night

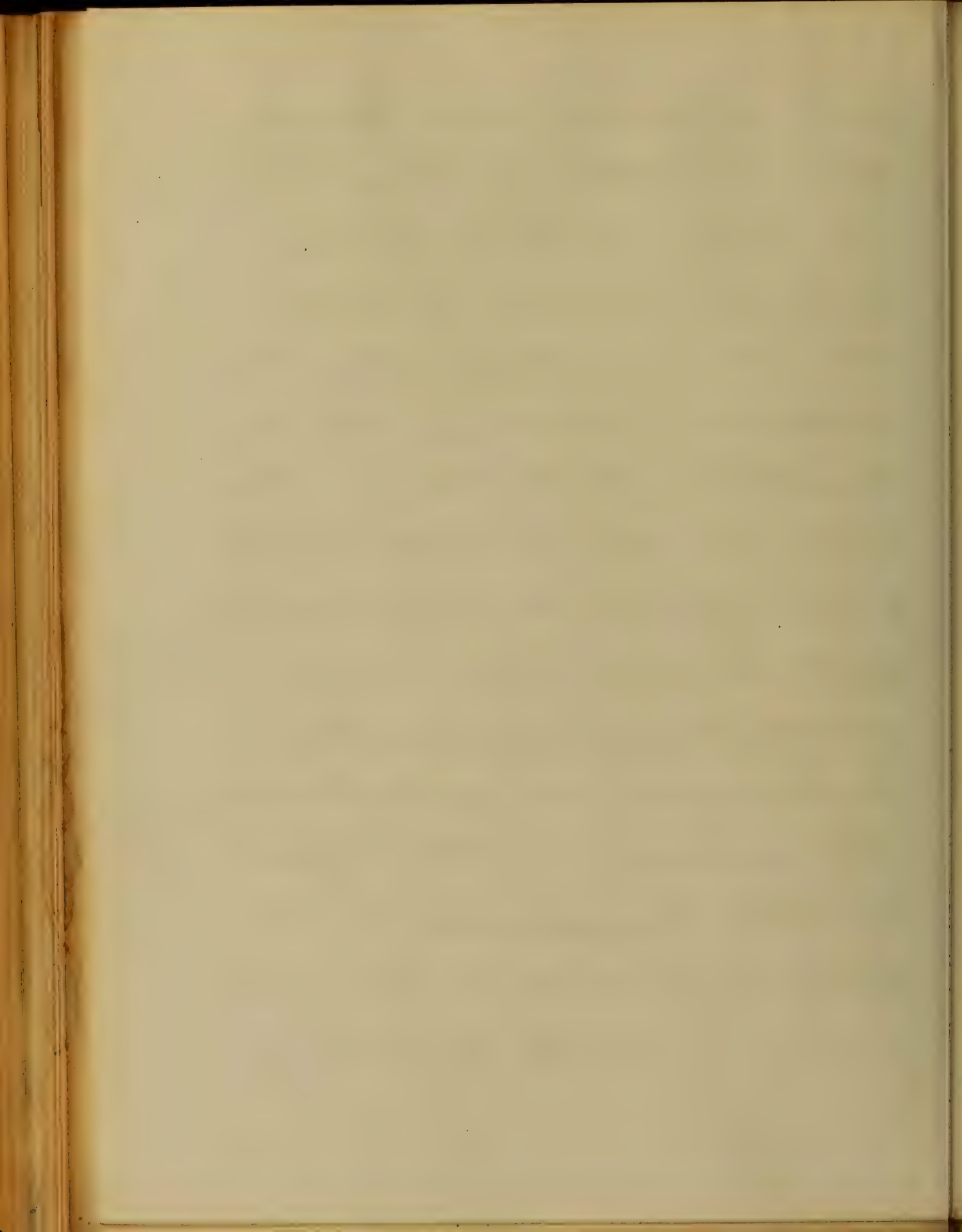


It is usually ushered in with a well marked rigor which may last for half an hour or even for several hours, (This rigor is important both in a diagnostic & a prognostic point of view. In no other affections excepting intermittent fever & Septicæmia do we encounter chills of equal violence & in the latter disorders the furaxisms are repeated while the rigor which ushers in Sarcinæmia is almost the only one throughout the course of the disease. It is from this chill that we calculate in count=

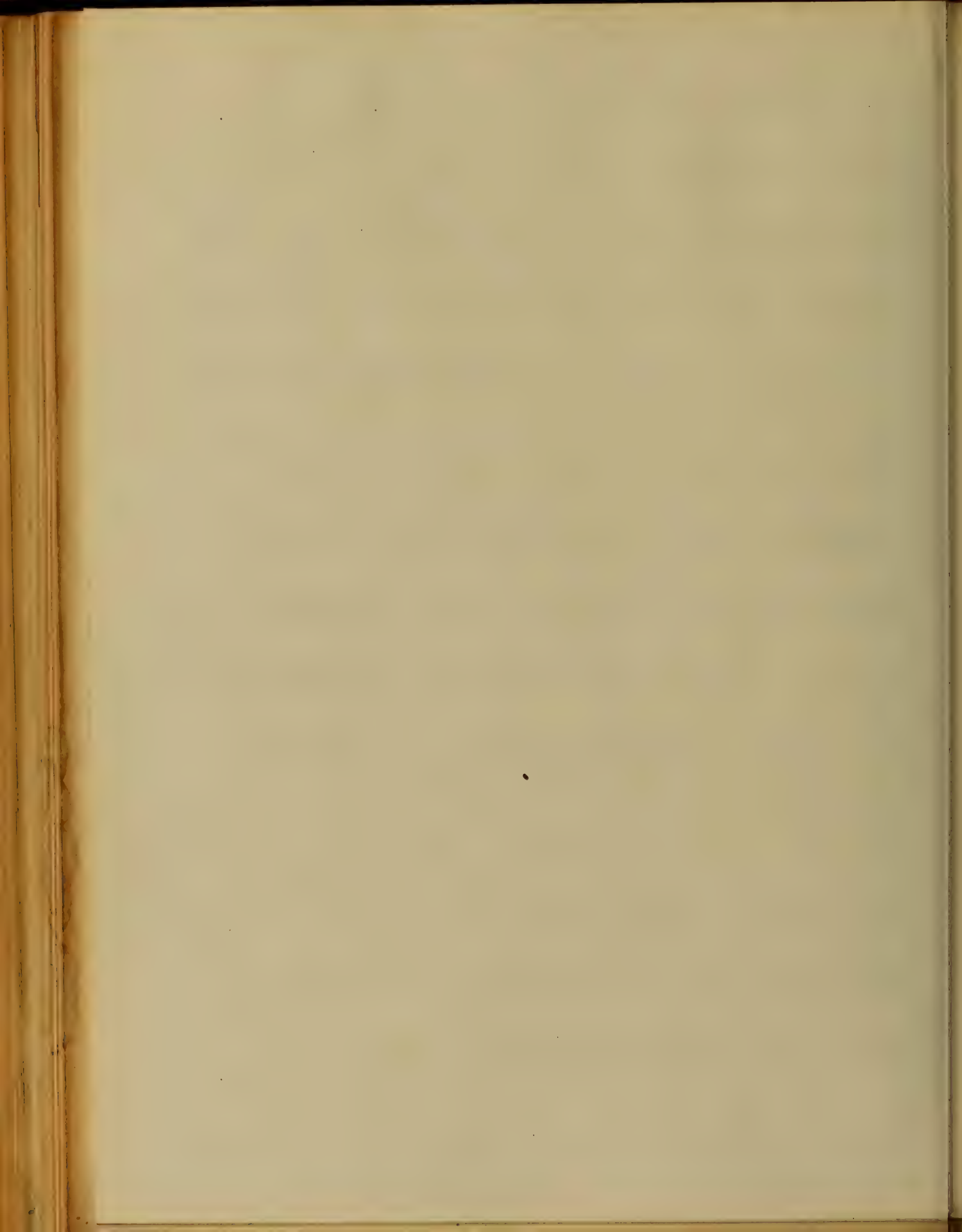


timing the duration of the disease
coincident with or speedily follow-
ing the chill is pain, it very
much resembles the pain of
pleuritis; very frequently this
symptom is wanting, but when
present it is acute lancinating
& usually referred to a circum-
scribed space near the nipple
of the affected side Cough is
usually present & frequently
accompanied by expectoration

The expectorated matter at first
is scanty, transparent & mucous
but it soon assumes characters
which are highly distinctive

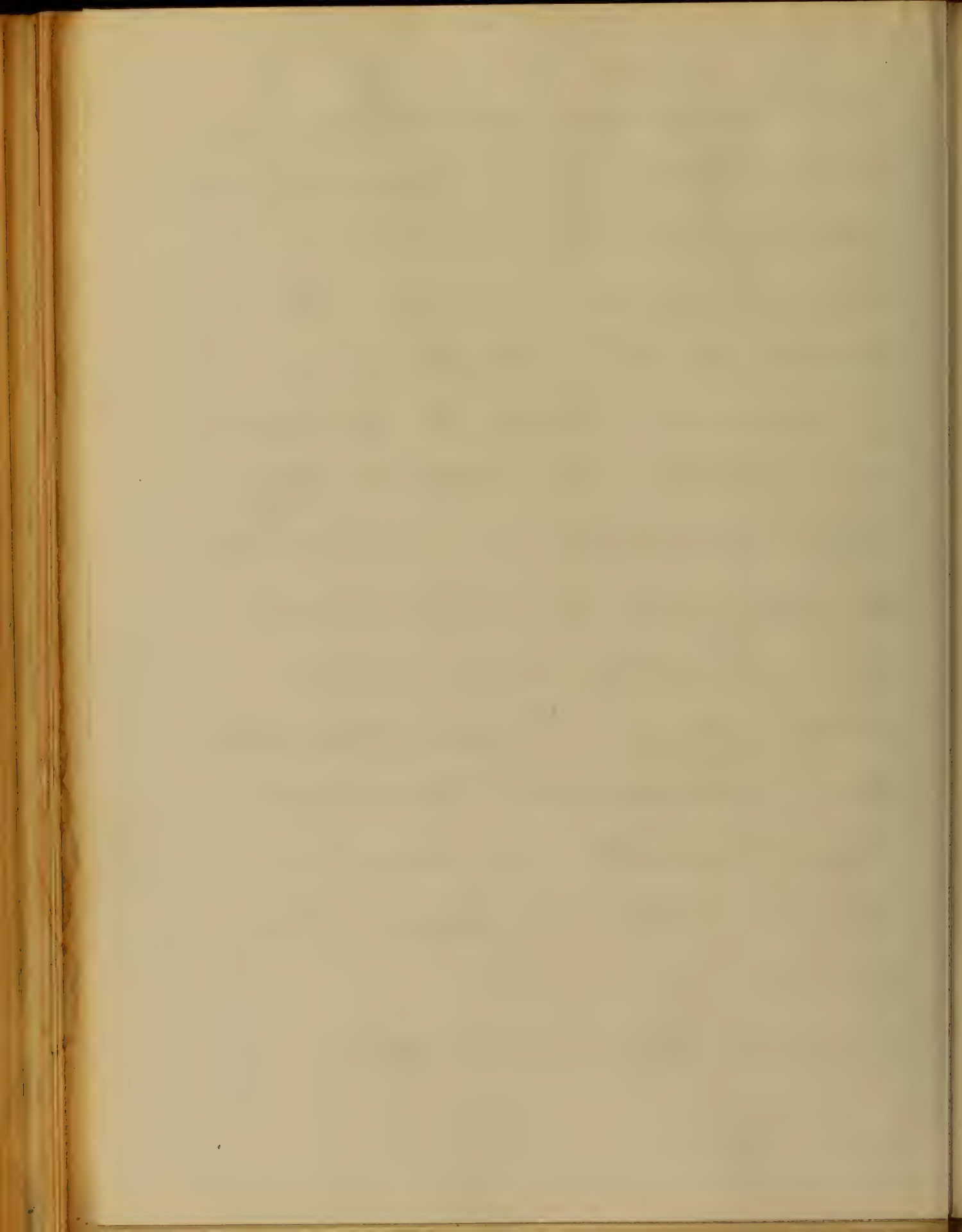


of the disease; that is, it becomes
Semi-transparent adhesive & has
a reddish tint, it resembles in a
great degree called misty & fector-
ation it is composed of mucous
lymph & blood; It is sometimes
Semi-transparent without the
reddish tint & in some cases it is
entirely watery, The pulse
varies in frequency in different
cases ranging from 80 to 120
pulsations per minute, is more
or less full & hard, There is fever
together with pain in the head,
thirst; heat of skin prostra-
tion & loss of appetite



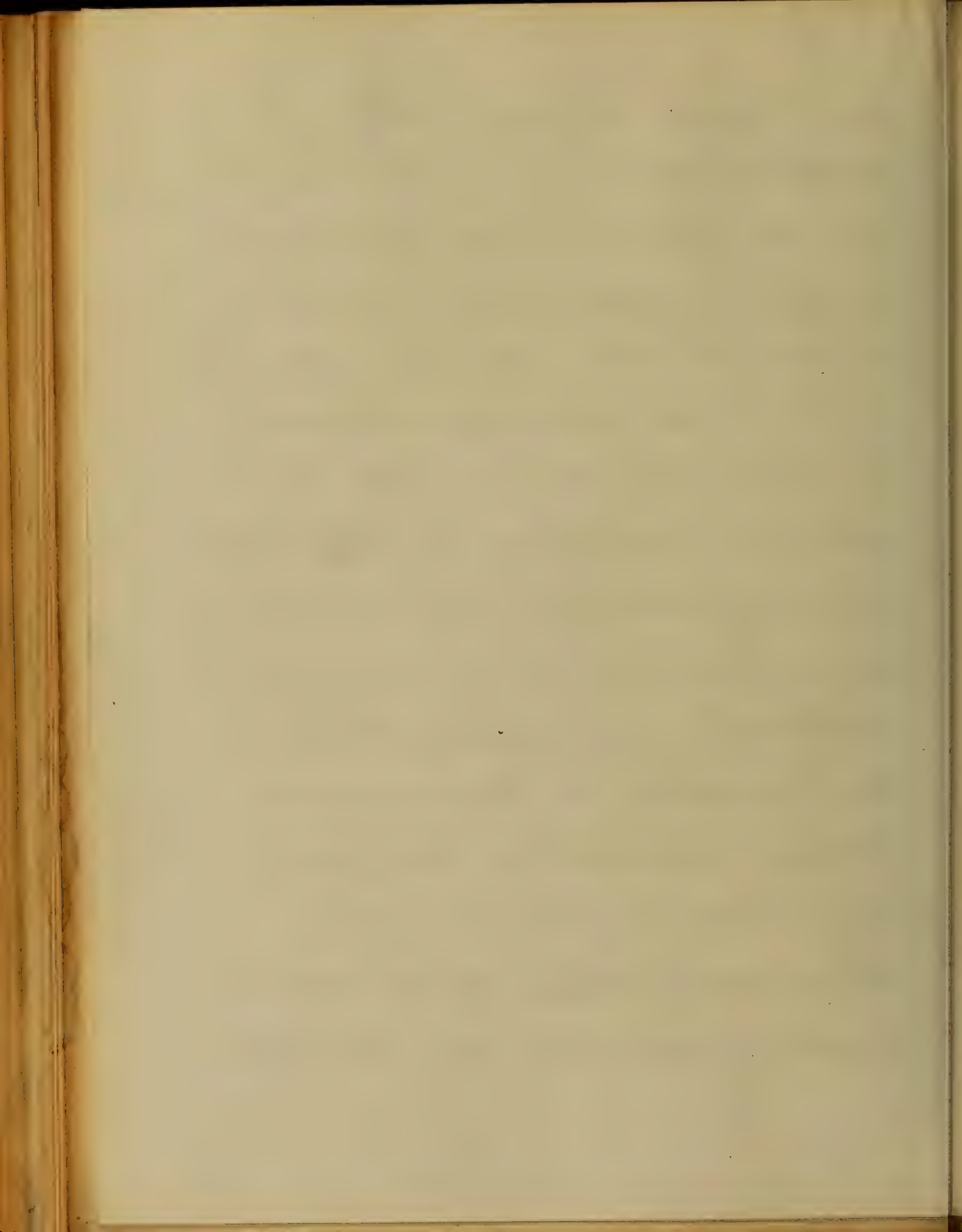
The thermometer denotes an increase of temperature ranging from 100° to 106° F. The respirations are increased in frequency. The height of the attack is usually reached between the fifth & seventh day after which the temperature declines & in favorable cases all the symptoms subside. When case terminates fatally there is increased prostration oppression in breathing cough deepens & expectoration becomes more abundant & fervent.

Physical Signs: then differ in



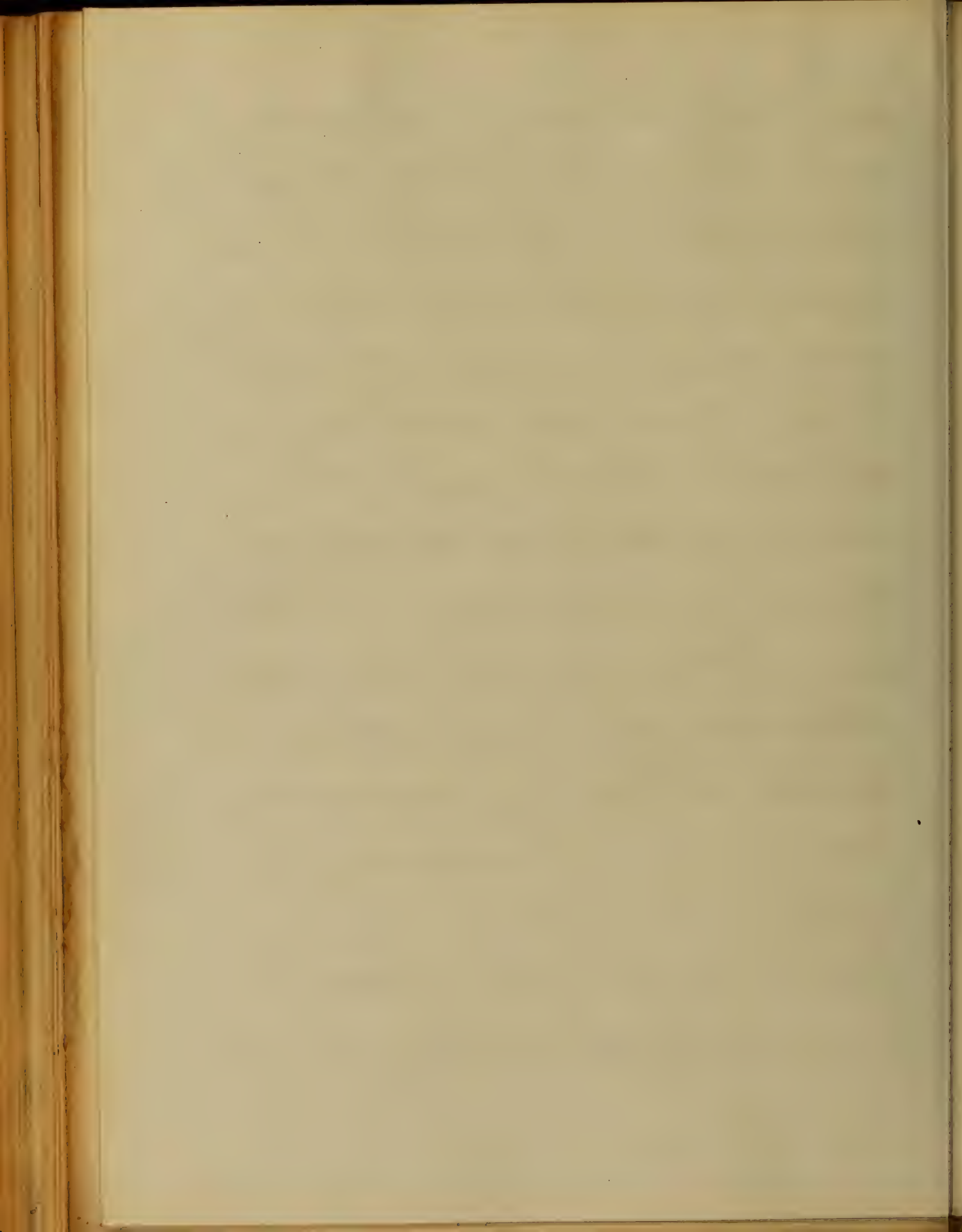
three stages; 1st stage They are moderate dullness on percussion over the affected lung & on auscultation after the first day or two the fine crepitant rale

2nd stage marked dullness on percussion no rale but instead bronchial respiration & bronchophony with increased vocal fremitus In stage of softening - suppurative or infiltration, dullness on percussion & coarse crepitant or mucous rale When resolution follows the second stage the bronchial respiration gives way to return



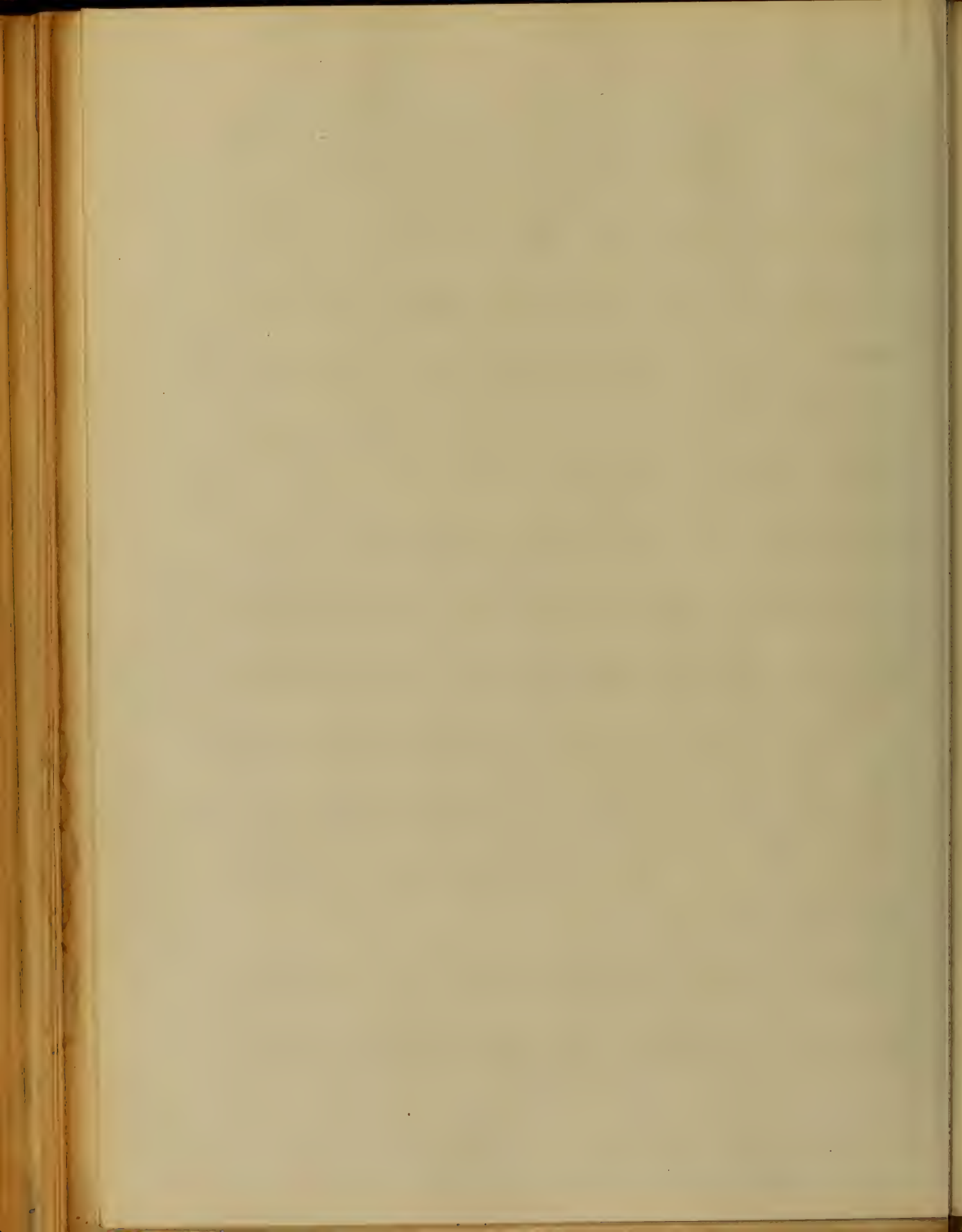
ming fine crepitation & the dullness
on percussion gradually disappears
Pathological characters acute
pneumonia, is an effusion
formation of a mucous mem-
brane characterized by an
exudation of lymph which
does not lead to the produc-
tion of new tissue & adhe-
sions & is not effoliated nor ef-
fectorated differing in this
respect from the exudation on
other mucous surfaces but
which is absorbed

Causation Pneumonia occurs
more frequently among middle



than females, & usually between
the ages of 20 & 40 years
In this country the disease first
rivals in the fall & winter more
more frequently than at any
other time, cold applied to
the chest is the most common
cause In a large proportion
of cases the disease is develop-
ed spontaneously not refer-
able to any causative agency
may be produced traumati-
cally or by inhaling irrit-
ating gases

Seat. The disease usually attacks
the lower lobe of the right lung

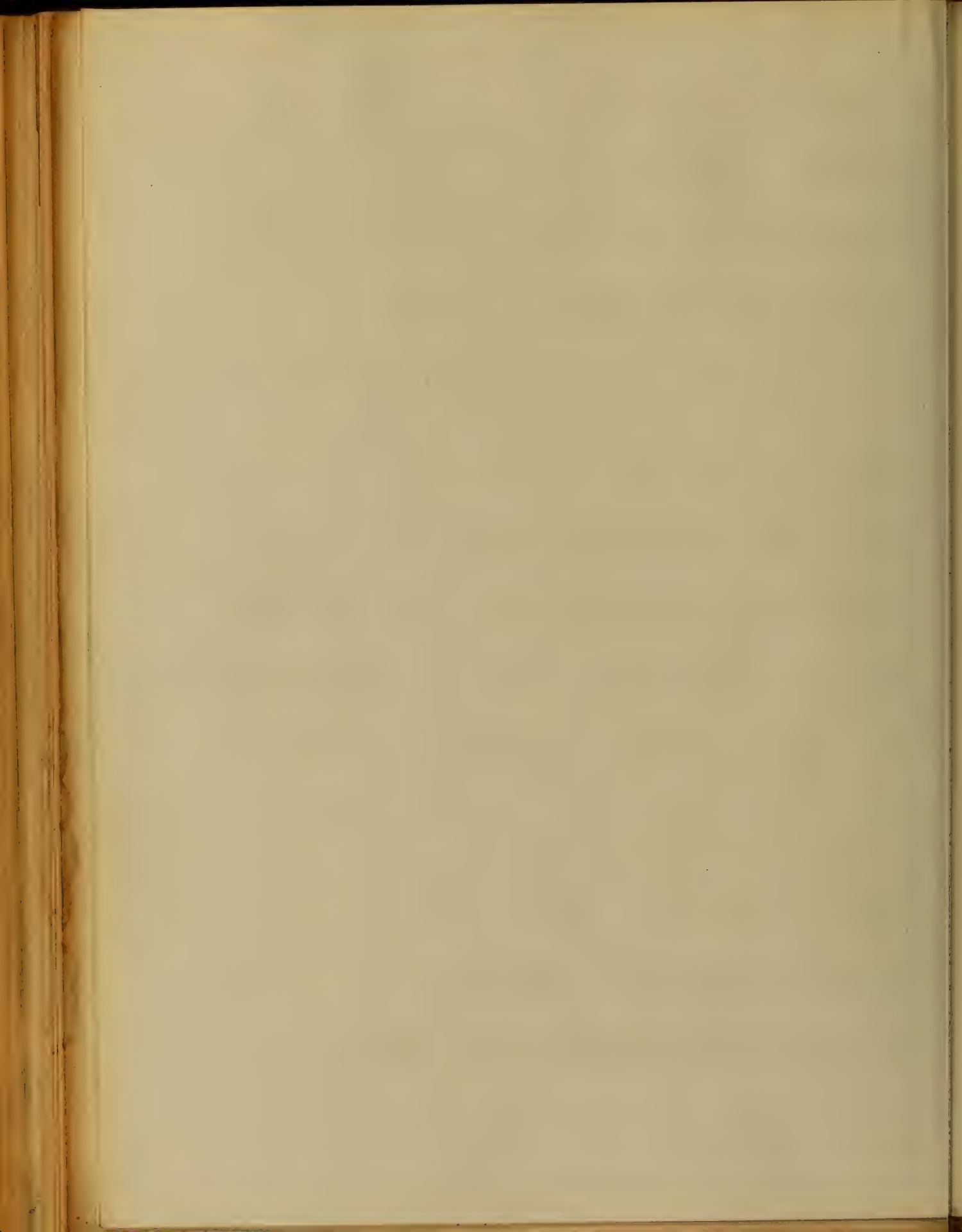


The disease rarely attacks two
lobes simultaneously but it not
unfrequently invades in success=
ion a second & third lobe

The inflammation does not ~~extend~~
from one lobe to another but
whenever a new lobe is affected
it is the seat of a new invasion

The disease is said to be double
when a single lobe on both sides
is affected or when the whole
lung on one side & a single
lobe on the other side

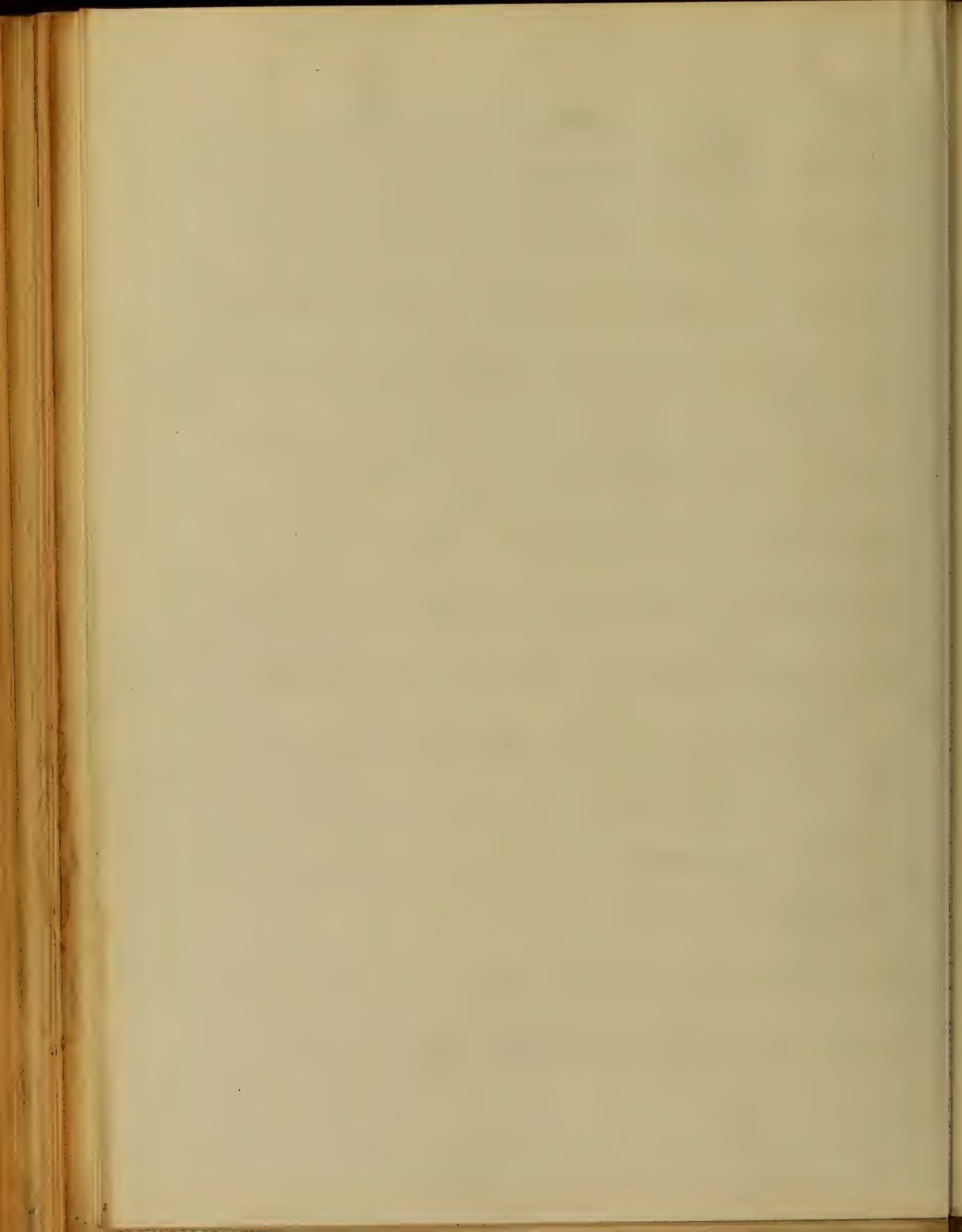
Diagnosis, The only affections
with which this disease is likely
to be confounded are Pleuritis



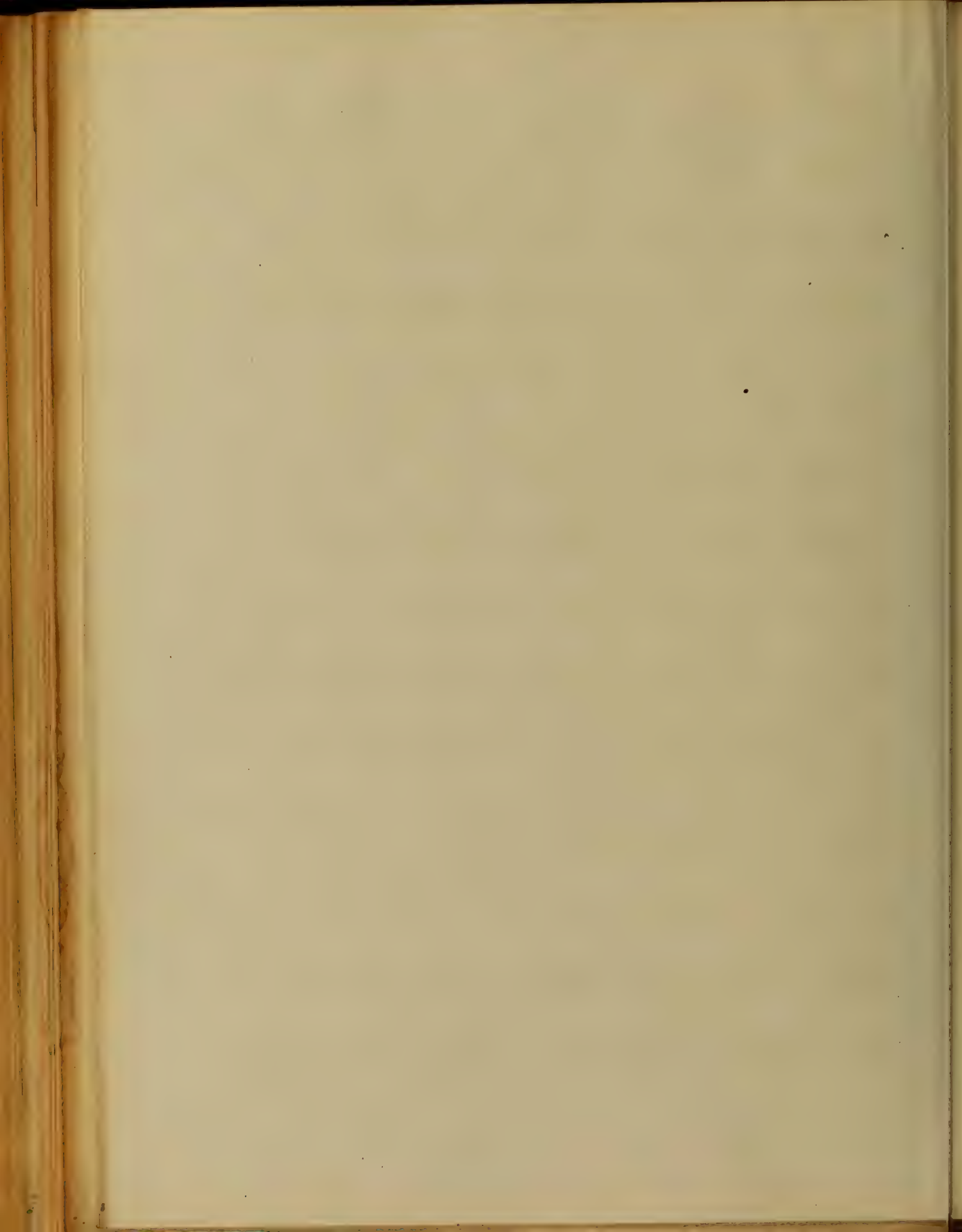
Bronchitis & Plethysis

1st stage The diagnostic symptoms are dullness on percussion & the crepitant râle, this latter symptom if persistent & well marked is almost pathognomonic of the disease, its distinctive characters are its fineness, dryness & limitation to inspiration, this symptom is not uniformly present. The rusty sputa is also a diagnostic sign of some importance.

2nd stage Bronchial respiration & bronchophony, there are

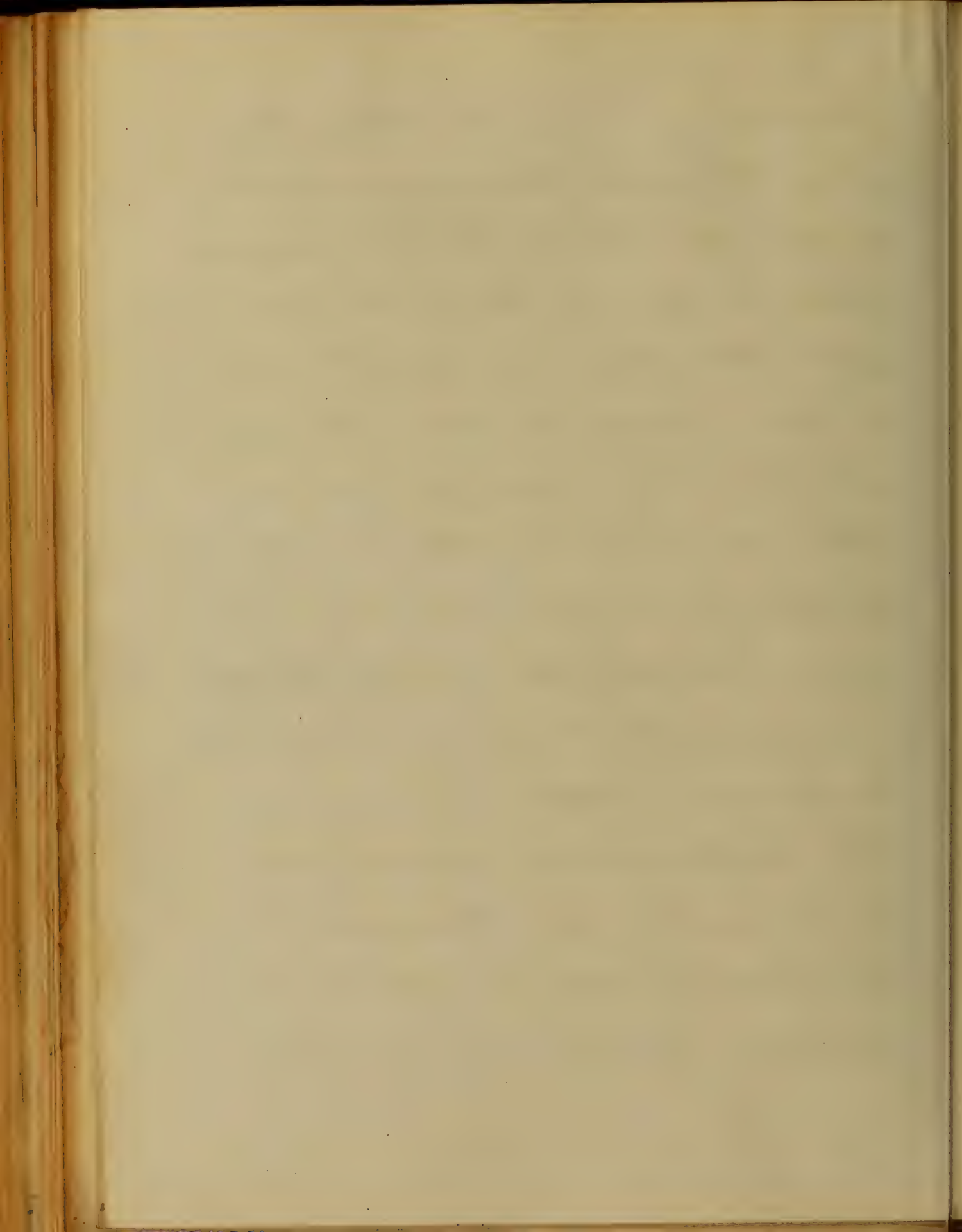


The signs denoting solidification
Dullness on percussion is well
marked. The stage of resolu-
tion is known by the bronchi-
al respiration giving place to
the broncho-vesicular murmur
& the latter progressively appro-
aches more & more to the
normal vesicular murmur.
If the disease pass into the stage
of suppuration the dullness or
flatness continues, & the moist
bronchial râles due to fluid
in the air cells are prominent.
The signs of solidification
continue but are less marked.



Prognosis The prognosis of uncomplicated pneumonia is favorable; But The prognosis depends to a certain degree upon The previous condition of the patient & upon the extent of lung tissue involved When developed in the course of other diseases it may prove fatal; it may terminate fatally in aged & feeble persons without being complicated

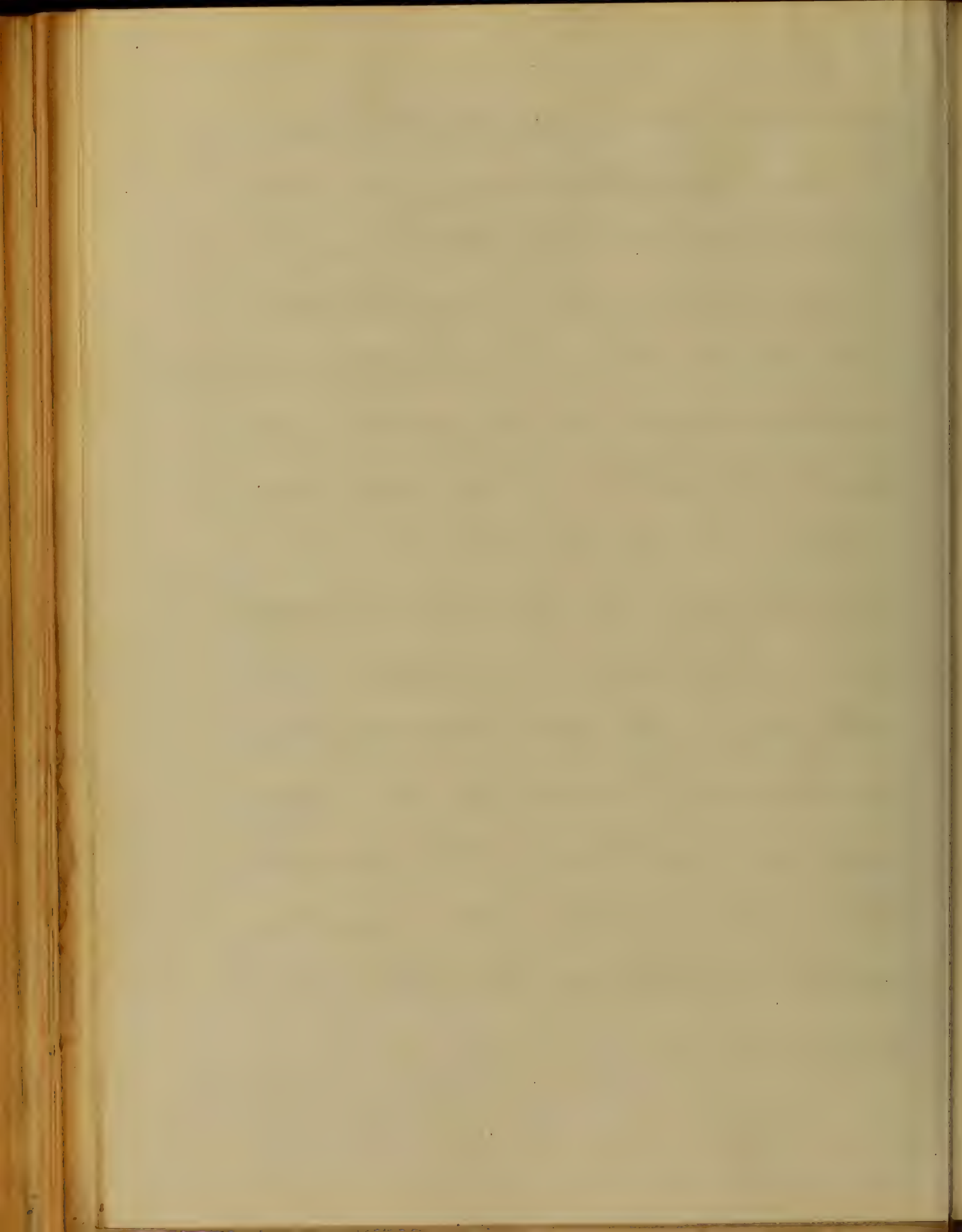
The complications which render it fatal are Pericarditis Intermittent fever & delirium Tremens, Death usually takes



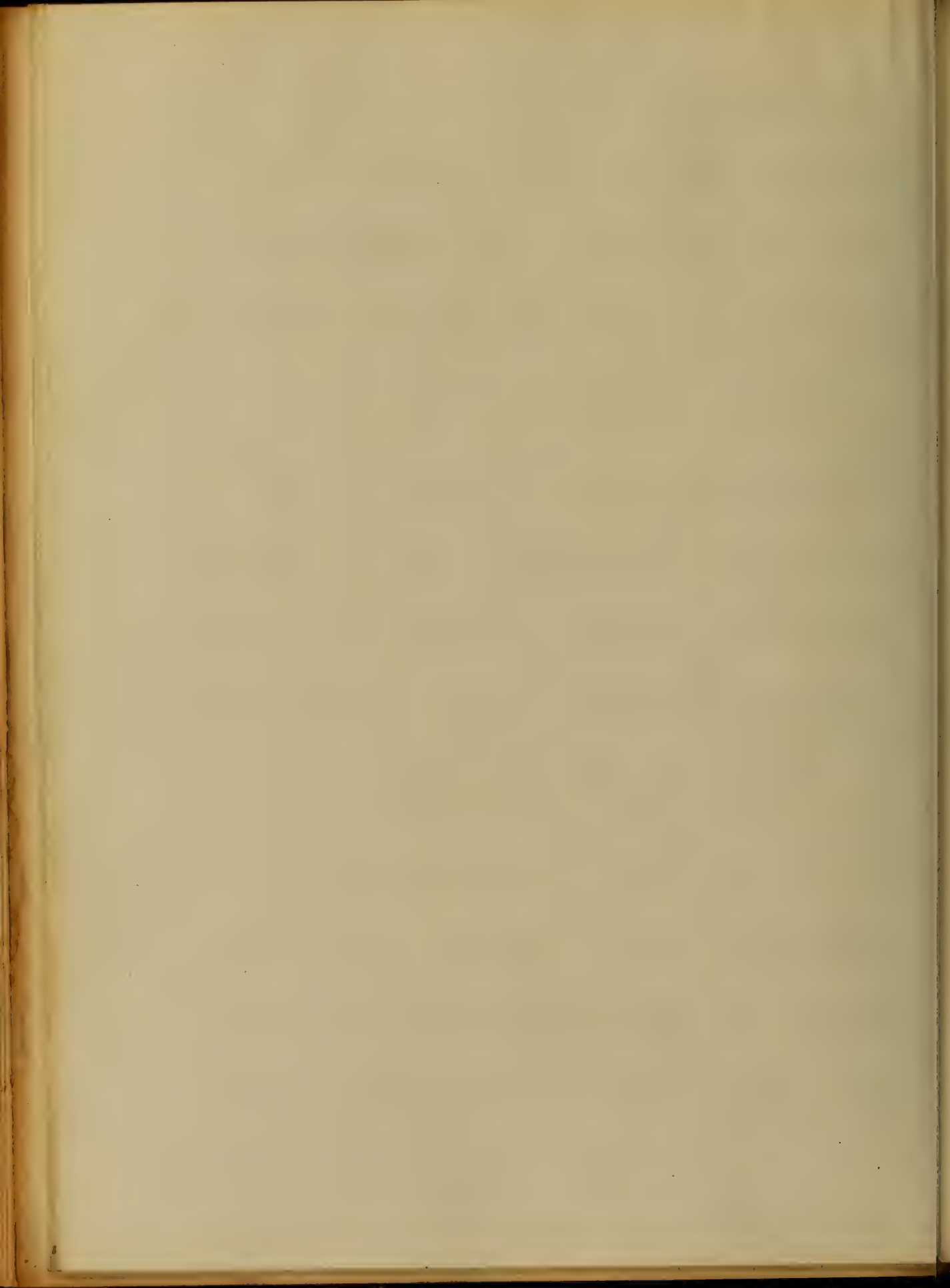
place by asthma or apnoea
Frequency & feebleness of the
pulse; hurried & laborious
respiration; an abundant
& purulent or mucous purulent
expectoration with active deli-
rium & prostration are unfa-
vorable symptoms

Treatment, The treatment varies
for the different stages

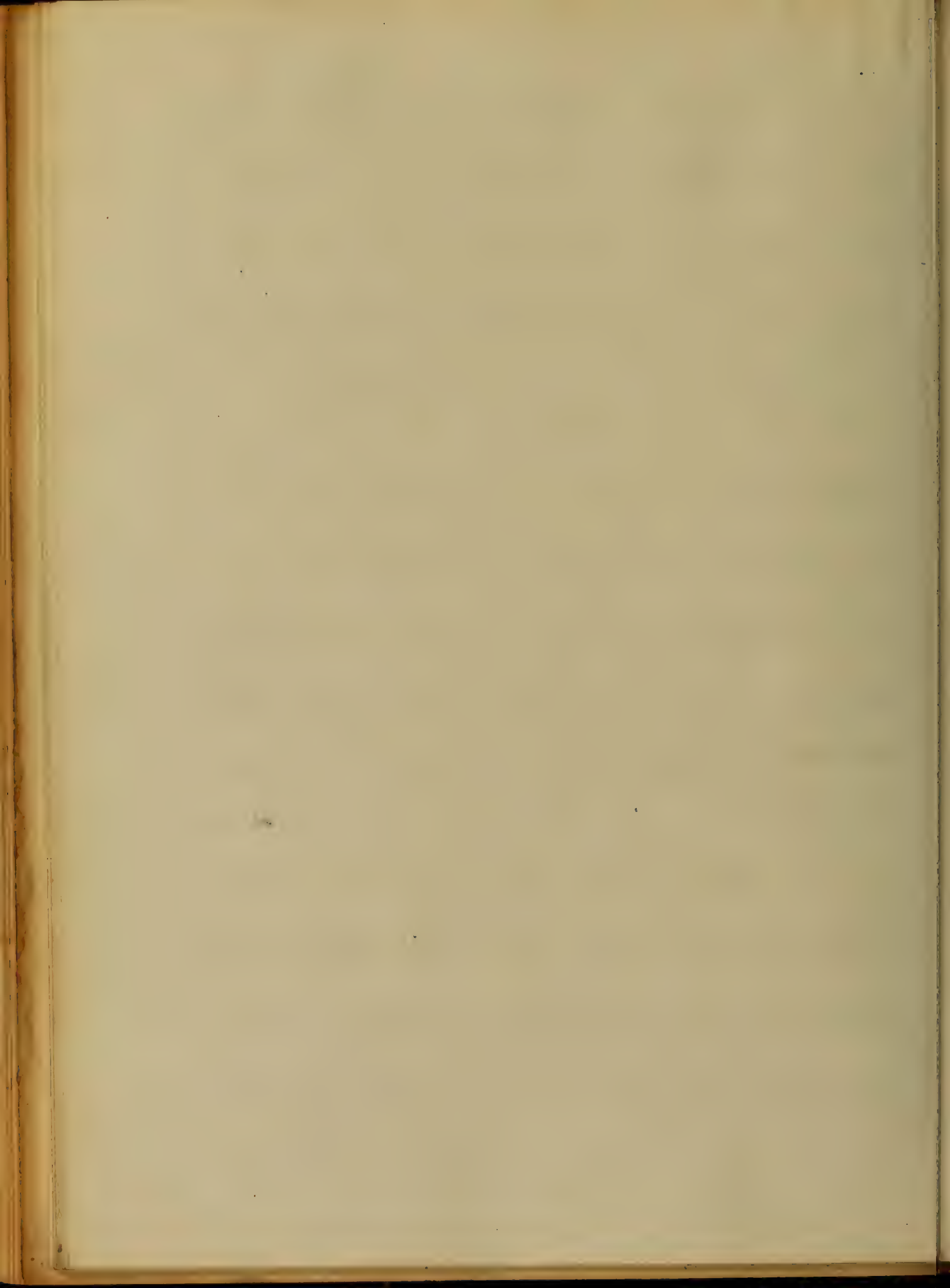
1st Stage The objects of treat-
ment are to diminish the inflam-
mation, palliate the symp-
toms & to place the system
in a condition to tolerate
the disease



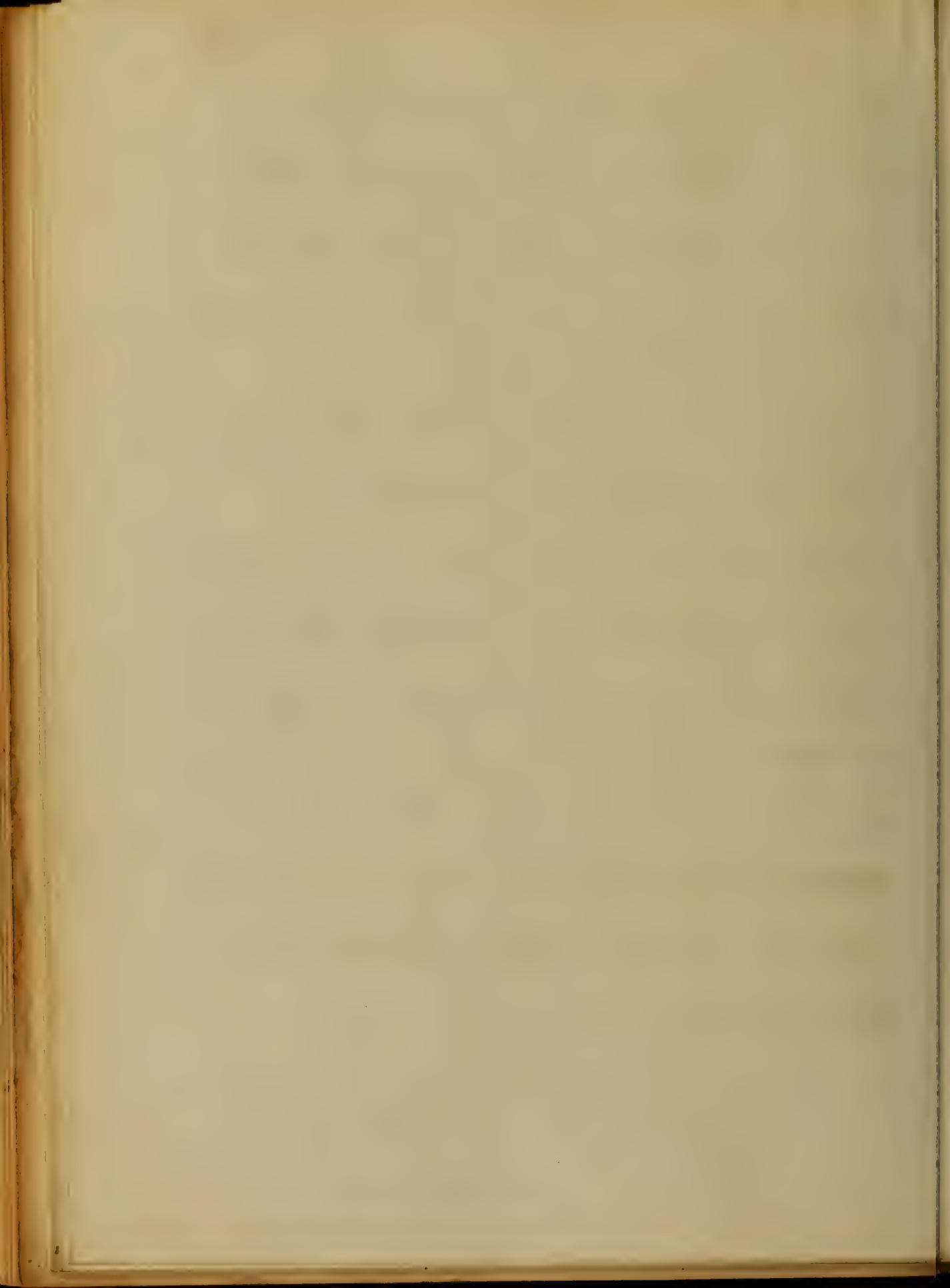
If there be much fever & the patient
slothome use local bleed-
ing, I have seen this tried
in the wards of The University
Hospital, several times & the
patients derived a great deal
of comfort from it, If the
skin be hot & dry give nitro-
us powder, For the fever use
some preparation of Opium
Novers powder is the one usu-
ally resorted to in this infer-
ary, Opium is undoubtedly
the most important remedy
used in the treatment of this
disease, Sinapisms & warm

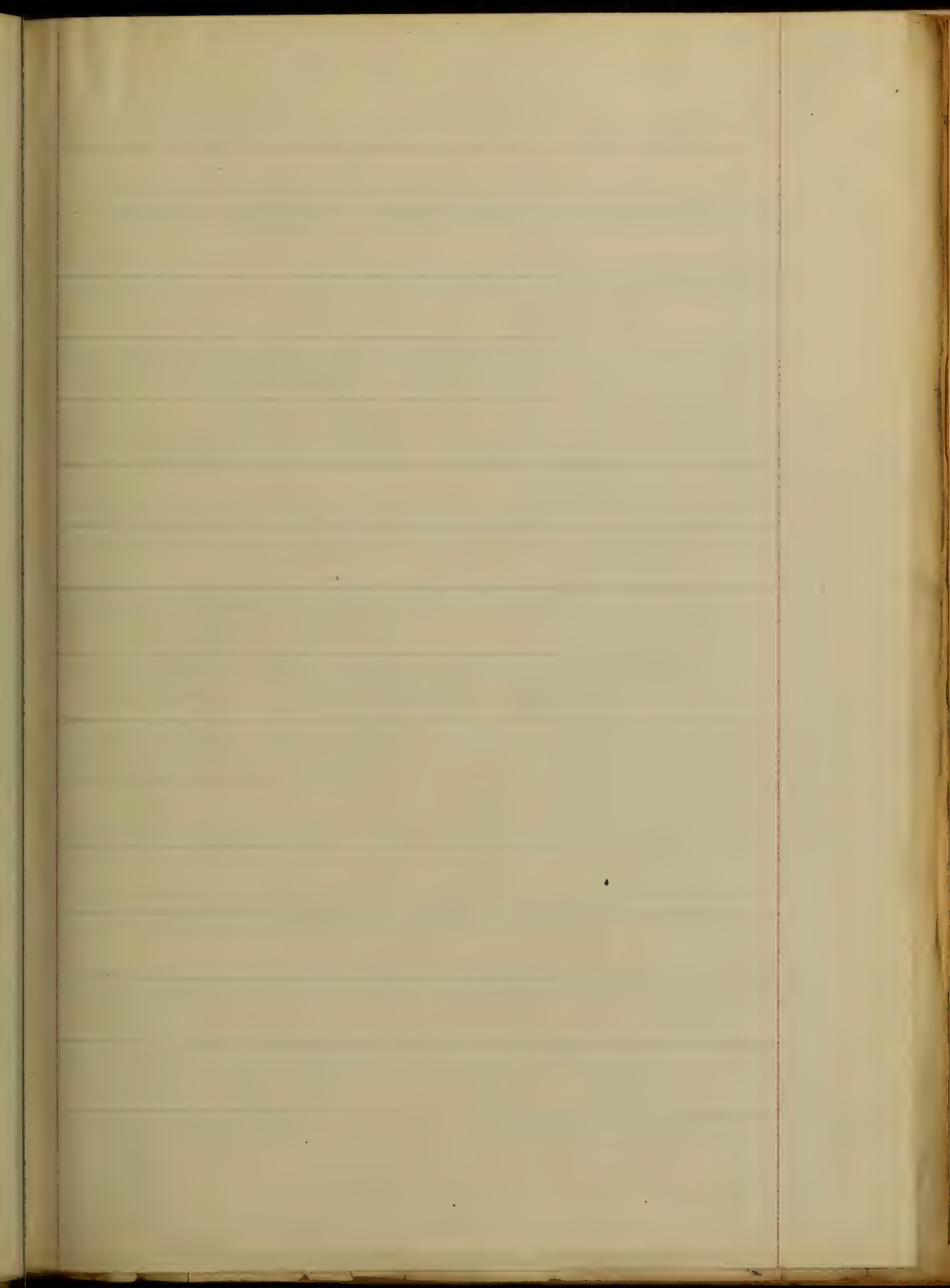


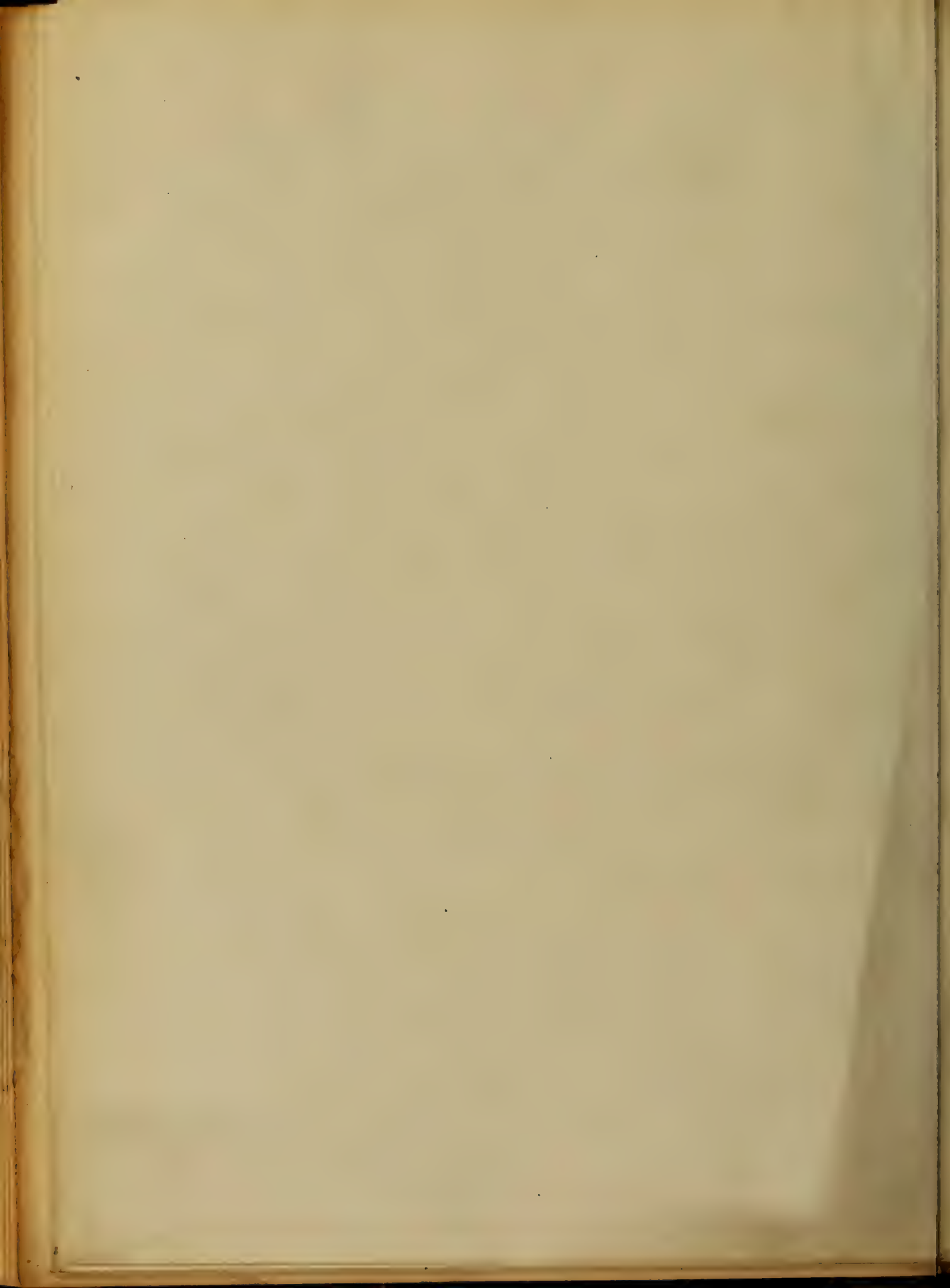
fomentations applied to the chest
are useful or superfluous depend
on the stage. The objects are to
promote resolution to relieve
the symptoms & to support
the powers of the system
The 1st of these objects is to
be accomplished by the use
of Friction of Lardine exter-
nally to the affected side or
warm fomentations may be sub-
stituted, if the pain continues
give Opium, to support the
powers of life. if a tendency to
death by asthenia give Tonic
remedies; alcoholic stimula-



with a nutritious diet, of the
Tonic remedies Quinia is the
one preferred at this hospi-
tal; Alcoholic Stimulants
are indicated to an extent
commensurate with the dan-
ger from failure of the
vital powers, The patient
should have a nutritious
diet as milk, animal
broths + farinaceous substan-
ces should form the diet
during convalescence if the patient
can be induced to drink; Cod-
Liver Oil &c







cc
Thesis, by

G. P. Sigler M.D.

January 1st 1877.

respectfully Submitted
to the

Medical Faculty

of

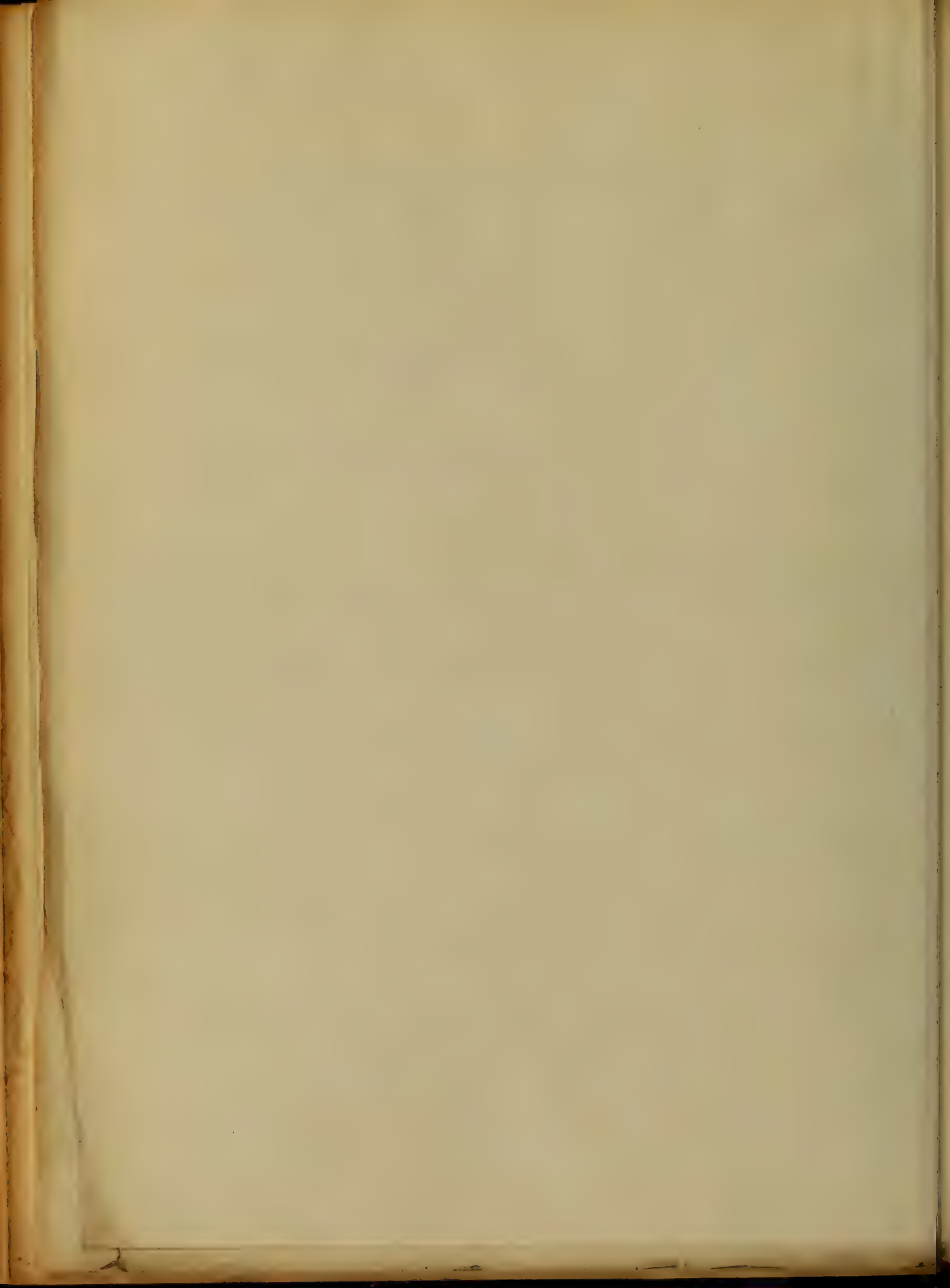
the University of Maryland

66

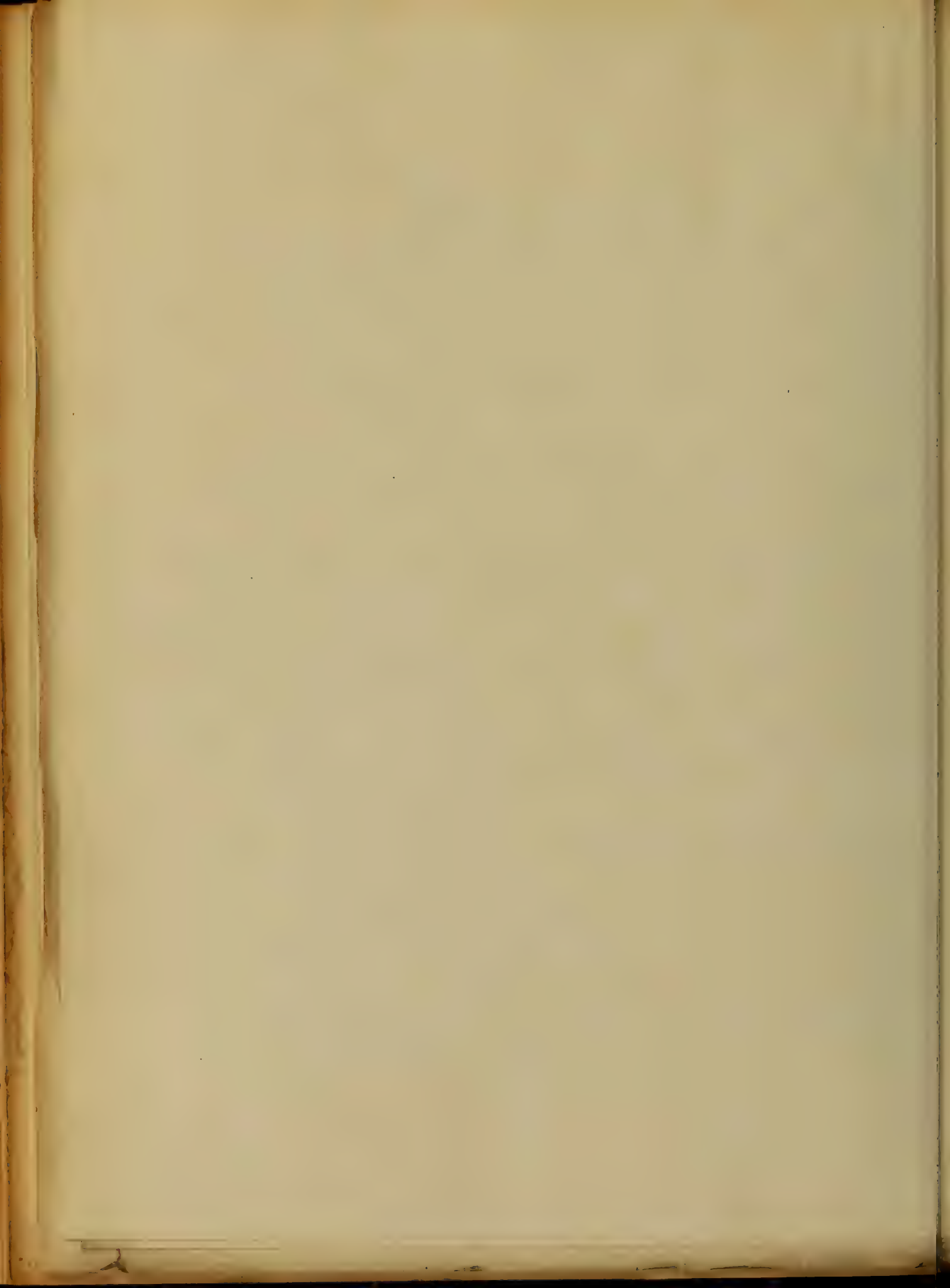
Hygiene, a practical, and most important Element in Education."

The great importance of hygiene "Hygienical Sanitation, and Hygiene" as elements in education, cannot fail to make itself obvious to the mind of every thinking, and intelligent individual. Yet it seems to have been so, and it is almost incredible that a subject of such vital importance, could up to the present day of enlightenment, have been so variously neglected.

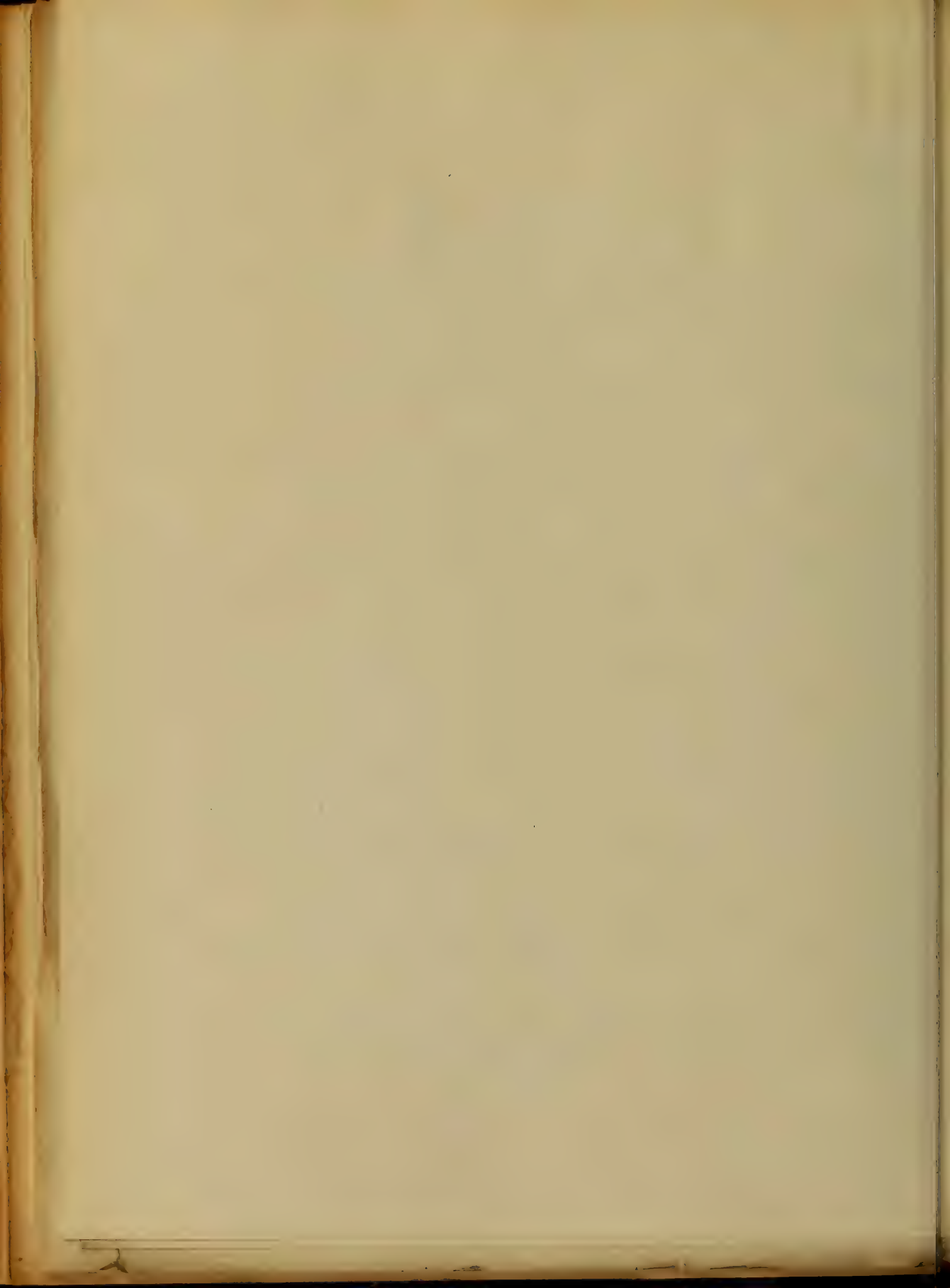
The cause of this is, probably not the least obvious, the want of sufficient stress being laid upon the subject, has given



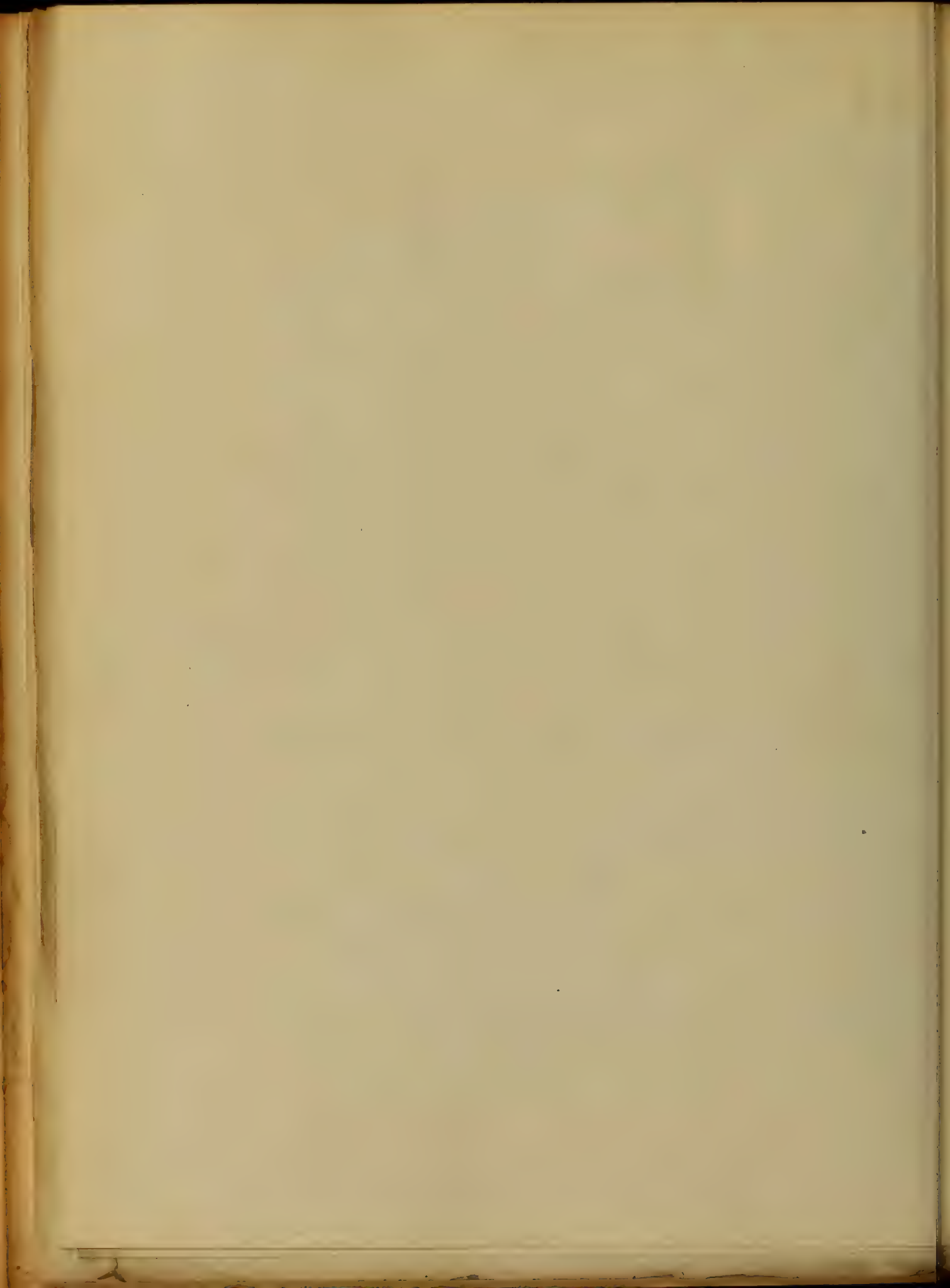
place to a spirit of indifference
 characterizing the mind, a pre-
 sence of all business is equal to the
 preservation of their own health, and
 their renderd out they more depend
 to an even by an ambition to as-
 pire to notoriety, and to rise in
 in, so called, fashionable society, while
 latter, as it exists today, is almost en-
 tirely inconsistent with the laws of
 health. The study of the human
 body, with its various functions,
 and the sacred laws which govern
 them, is not to be made with the same
 importance as in the study of
 less freightful, and life more tolera-
 ble only, but it is out of the way.



interesting and elevating in char-
acter. Nothing can more effectually
enlarge the mind, the immeasur-
able wisdom of our great Creator
than that wisdom and sublime
architecture, which is displayed
in the building up of that most
godlike and wonderful edifice,
the human body. Culture is this
a subject requiring great careful
prolonged study, and to ac-
quire a thorough knowledge of it,
man is to be the possessor of which
with proper precautions, is com-
patible with any of the trades, in
creation of life, and involving
the sacrifice of the dust of the world.

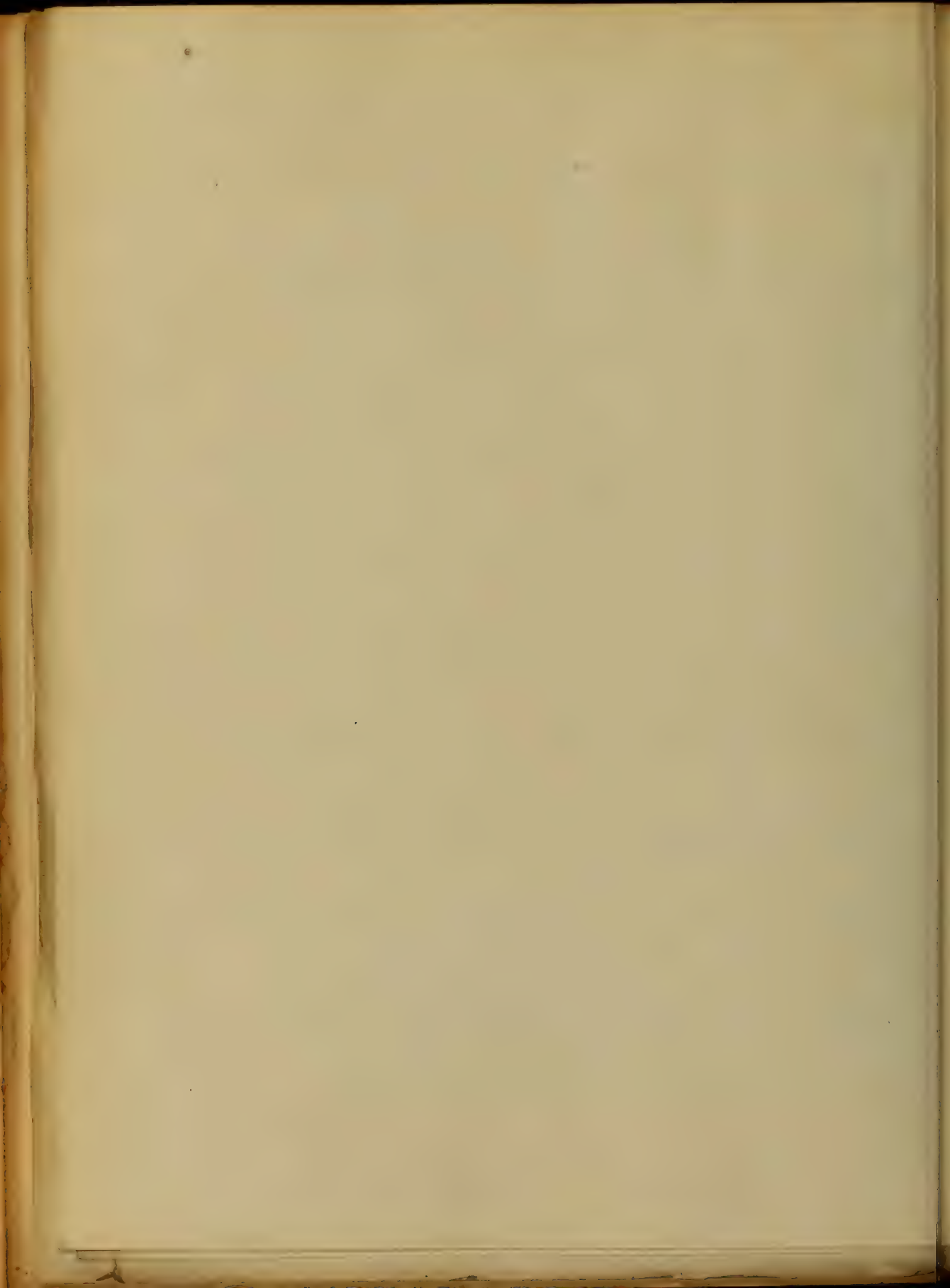


and true enjoyment of life; and
 to pursue them to whatever
 end and how far. It is
 an education to the nature
 of our desires, so that they
 be essential to the enjoyment of
 perfect health, as the simple hygie-
 nic rules, is an admirable
 and subtle course should be
 fully considered. We now
 see persons in possession of
 sufficient knowledge of the
 hygienic rules, and the art of
 maintaining them, but ignorant of
 observing persons; and I have
 observed physicians have learned
 that it is almost always a



that advice, or business, or studies,
to induce them to abandon long
formed and expensive habits of
fashion or taste, and give their
attention to the preservation of their
health, until death or the dread of
death stares them in the face, and
then it seems very unjust and hard to
them, that it should require any
care, or sacrifice on their part in
order to sustain the continuation
of all the various and complicated
functions of that most perfect
organism which the divine Creator
has given them to take care of.

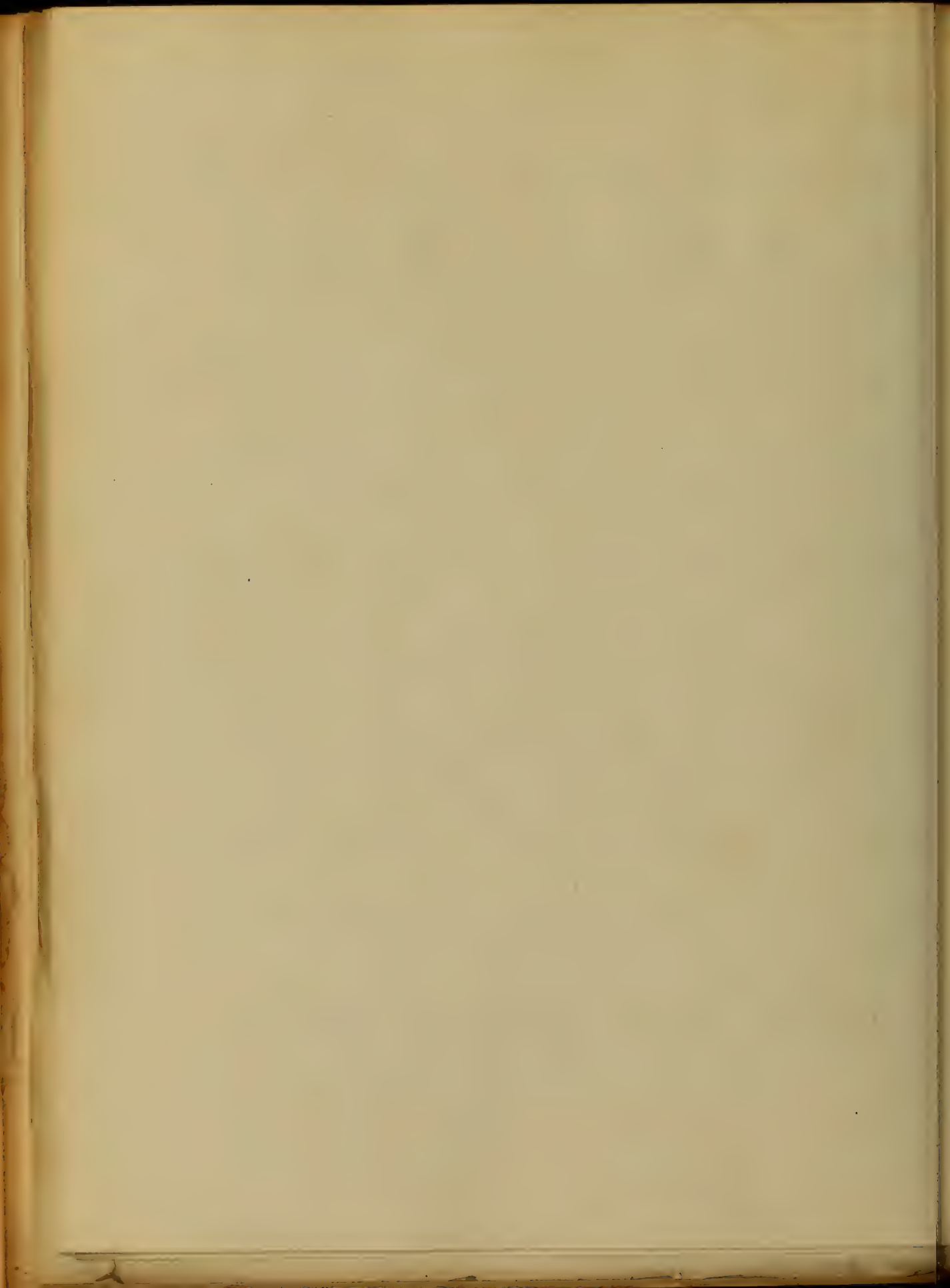
And especially does the state of
affairs exist in our large towns

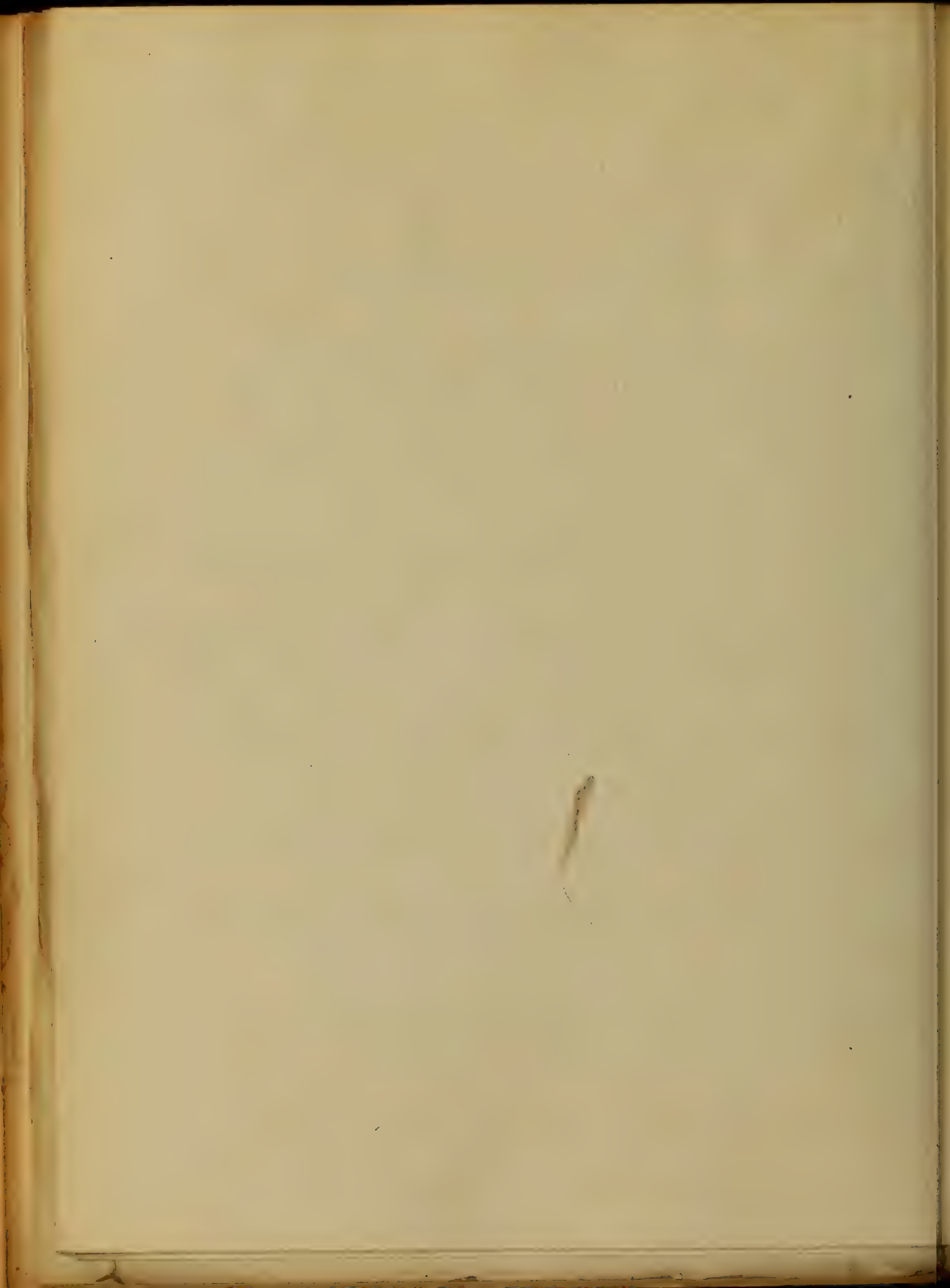


and cities where the rules of fashion
are pursued, and monopolize
all others to a great extent.

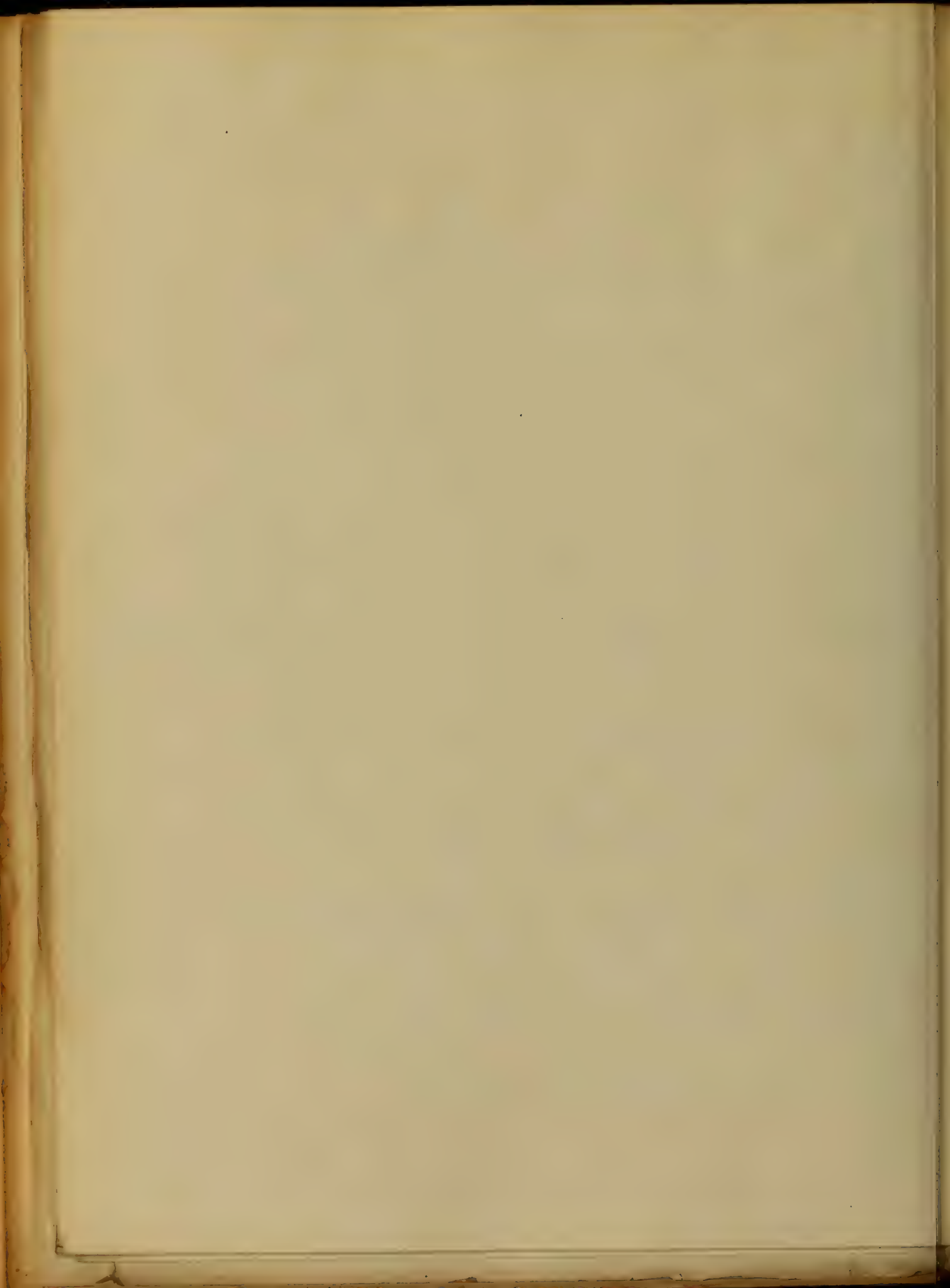
Why this is all true I do not attempt
to discuss, but it is not
impossible to put into practical use
the laws of health, nor, as stated
above, can I conceive that

the best interference with
any of the necessities of life, is
far from this, is it, that to those who
do not appreciate their value, the
observance of them becomes a
source of great happiness, and
such a course properly carried
out, I doubt not would suffice to

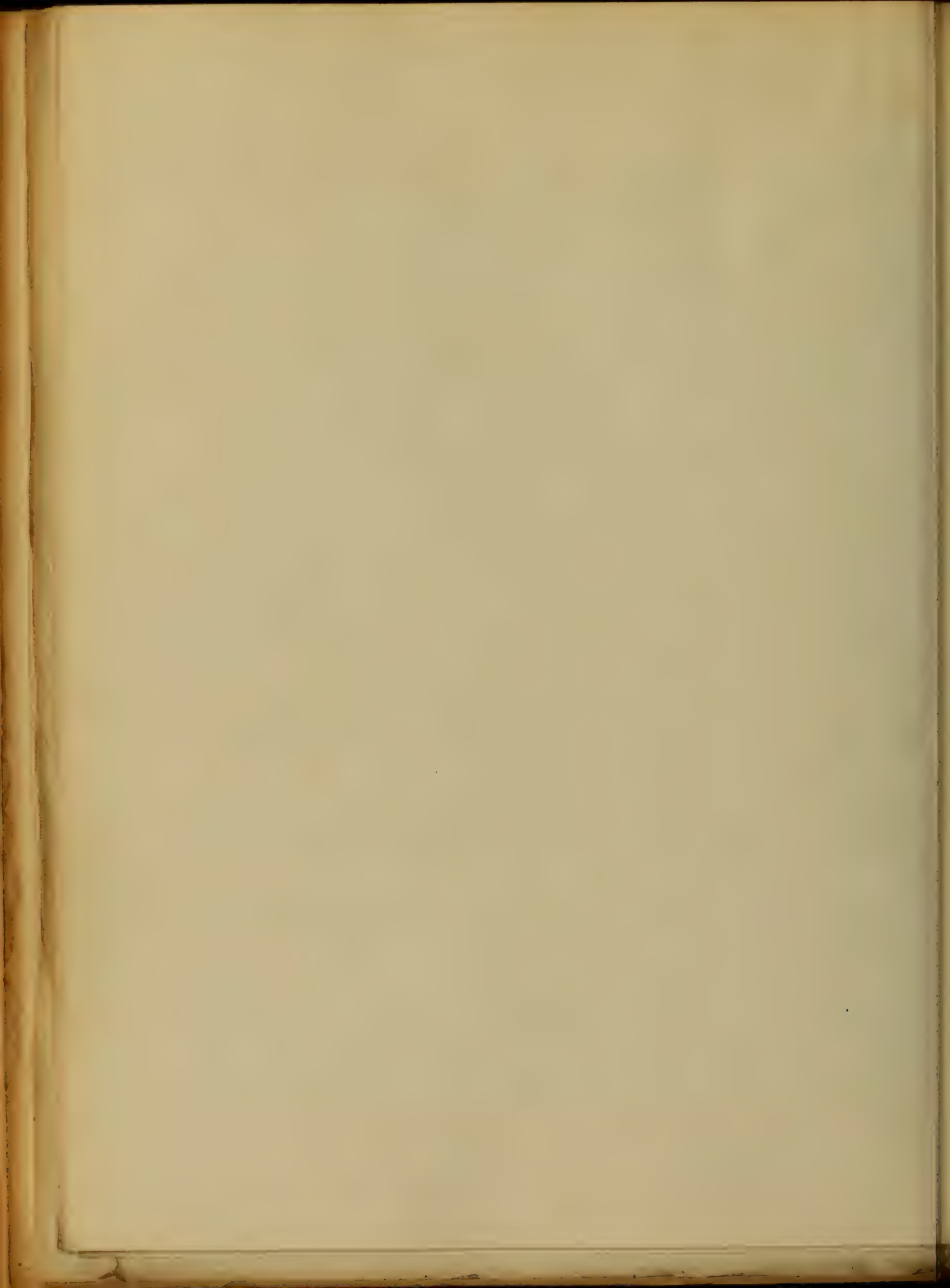




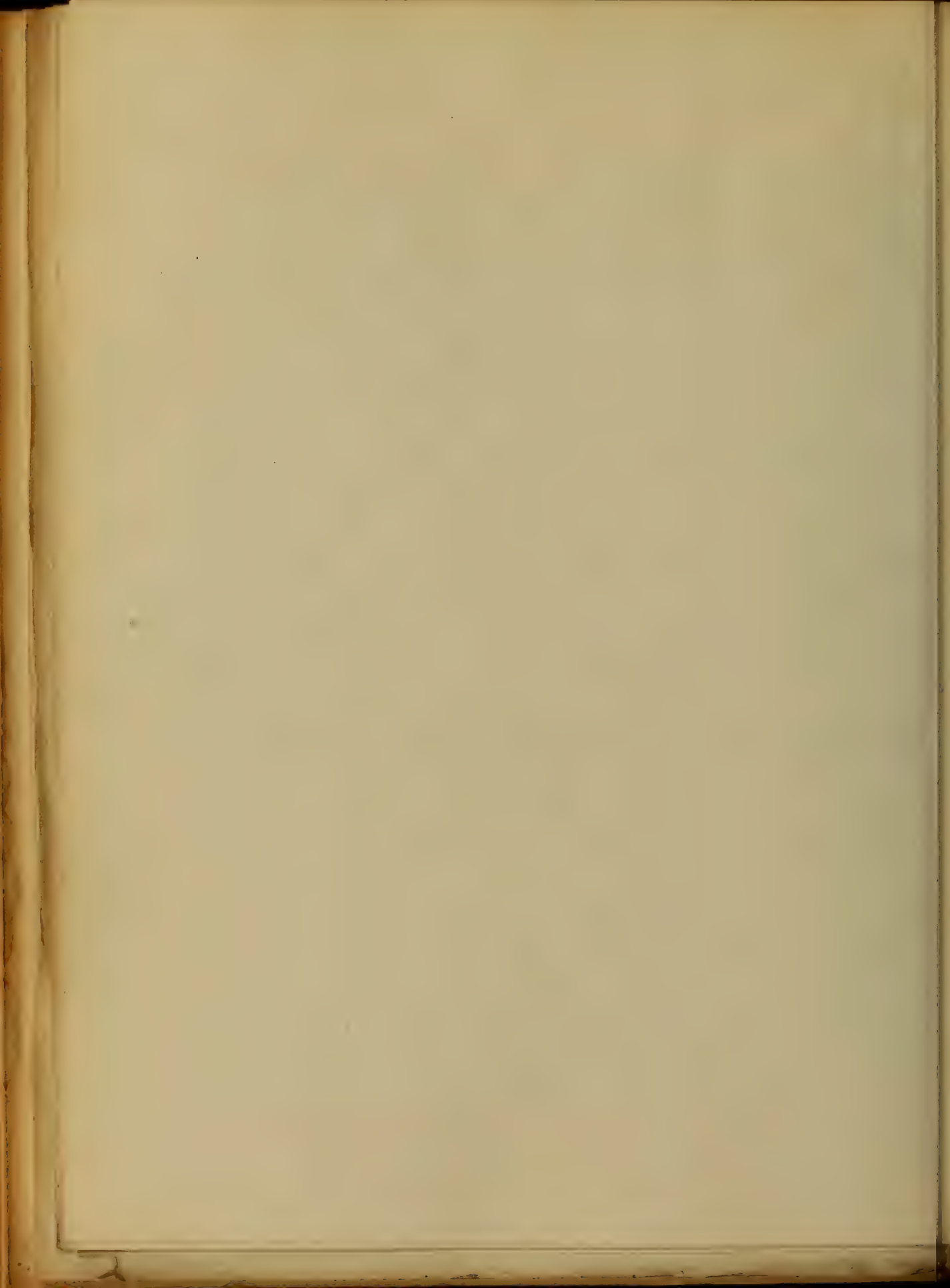
at least a small amount of the social
tality occurs in childhood from years
of age and under, yet after am-
ple allowance for the ordinary
size and imperfections in the
developmental process, the cause
of many of the ills of this country may
be traced back to the want of a habit of
honesty in our people. The people
by indeed do want to be honest, but
they do not know how to satisfy their
own consciences in the
the case of the aristocratic life, suffer their
leaders of opinion to be subjected to
the same kind of judgment as the
land owning, at least of some
quality from an uneducated



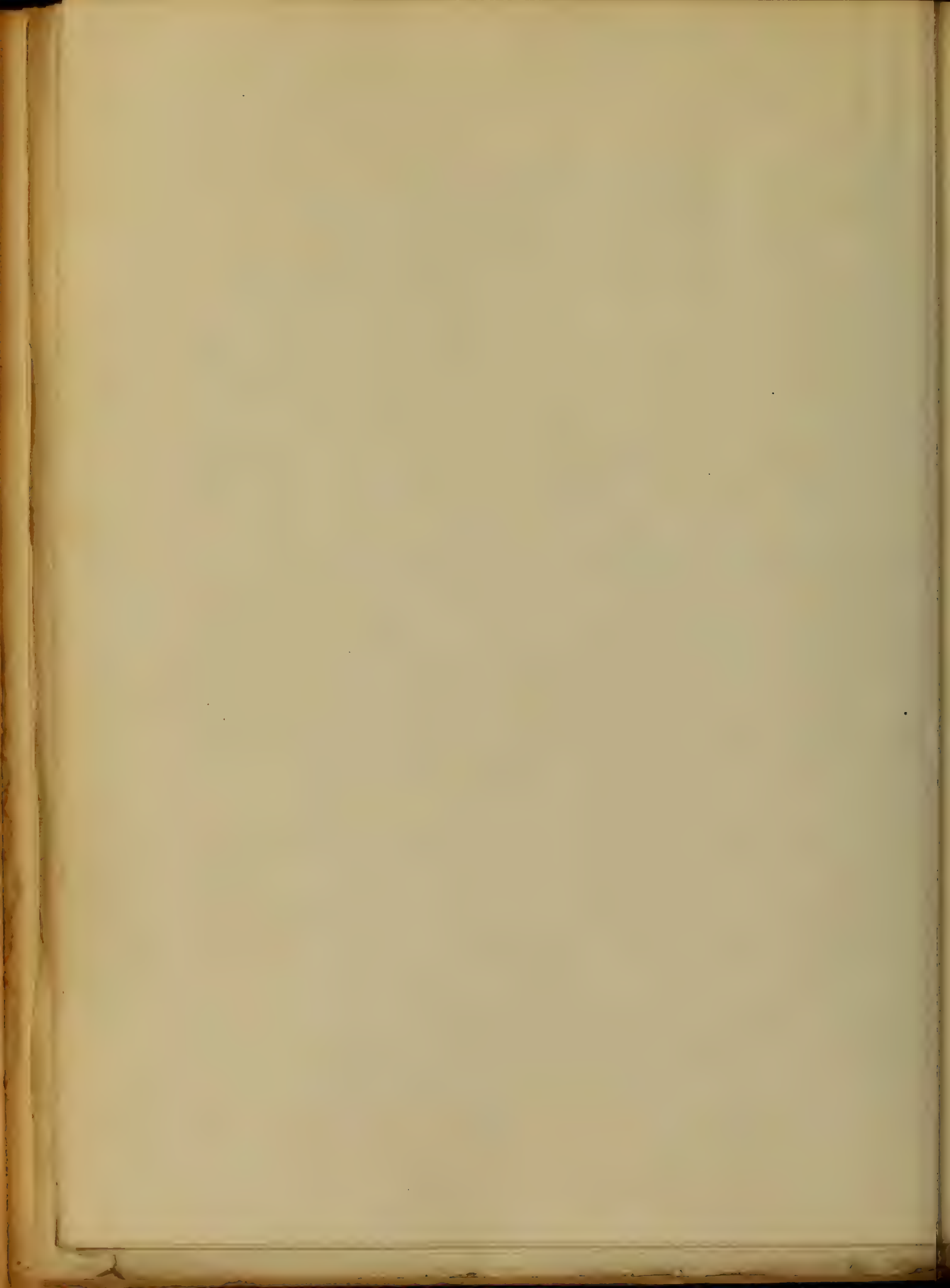
8
Liberate course, thus rendering the
mind, untrammelled, untrammelled, as
a mother's care and duty, is
sacred, and which is an untrammelled
up to this more temperate period of life;
consequently the way of life is
child. But a very narrow range
of surviving the period of infan-
cy. Again it is very unfortunate
that the energetic, and ambi-
tious spirit which distinguishes the
people of the "United States" has
prompted them to the adoption of
a mode of education so prejudi-
cial from its necessity. Children
of tender years, are requi-
re of the untrammelled, untrammelled

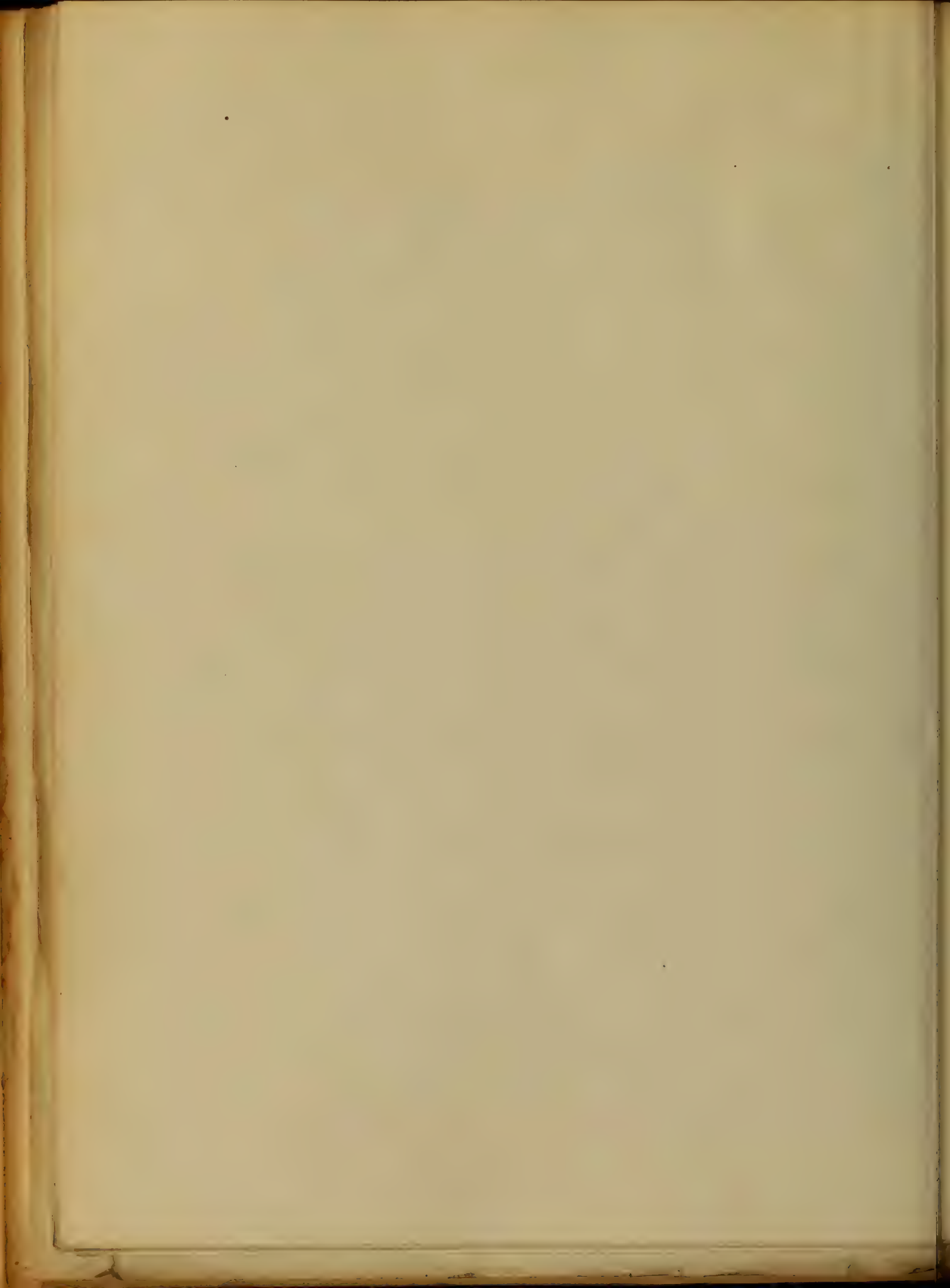


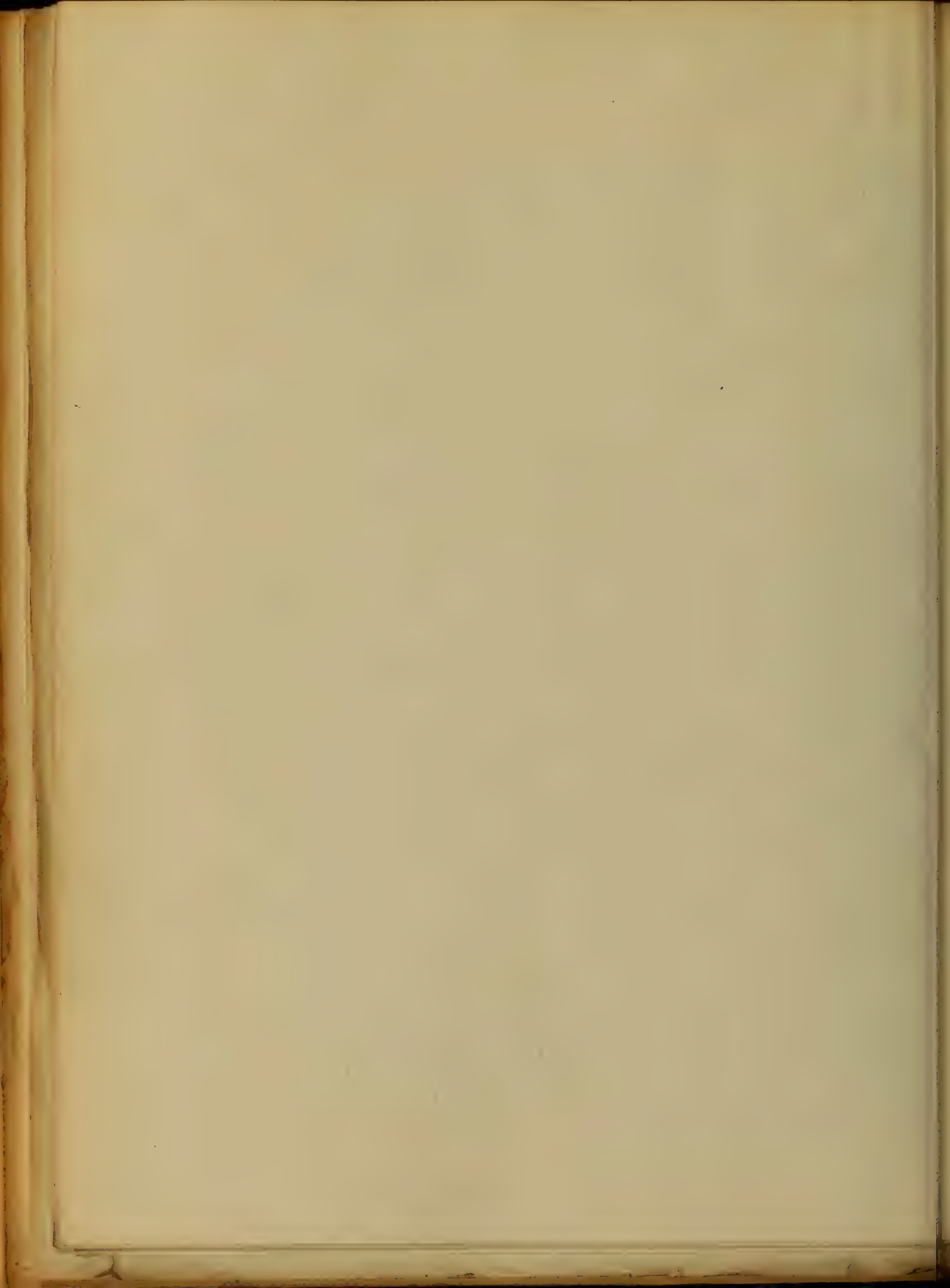
to ~~over~~ studies, that are too hard
 for them, and to tax their intel-
 lectual faculties with notions of thought
 and memory too burdensome and
 unprofitable for the young and in-
 accessible stages of their education
 to us, and all this combined with
 the most intolerable hygienic
 circumstances, such as confinement
 at for hours at a time in crowd-
 ed, and close rooms of unwholesome
 complexion, and deficient ventilation,
 and food that is improper, and
 that is ~~not~~ ^{not} ~~of~~ ^{of} the
 most nutritious and muscular
 nature, and the ~~most~~ ^{most} ~~of~~ ^{of} the
 most ~~of~~ ^{of} the ~~most~~ ^{most} ~~of~~ ^{of} the

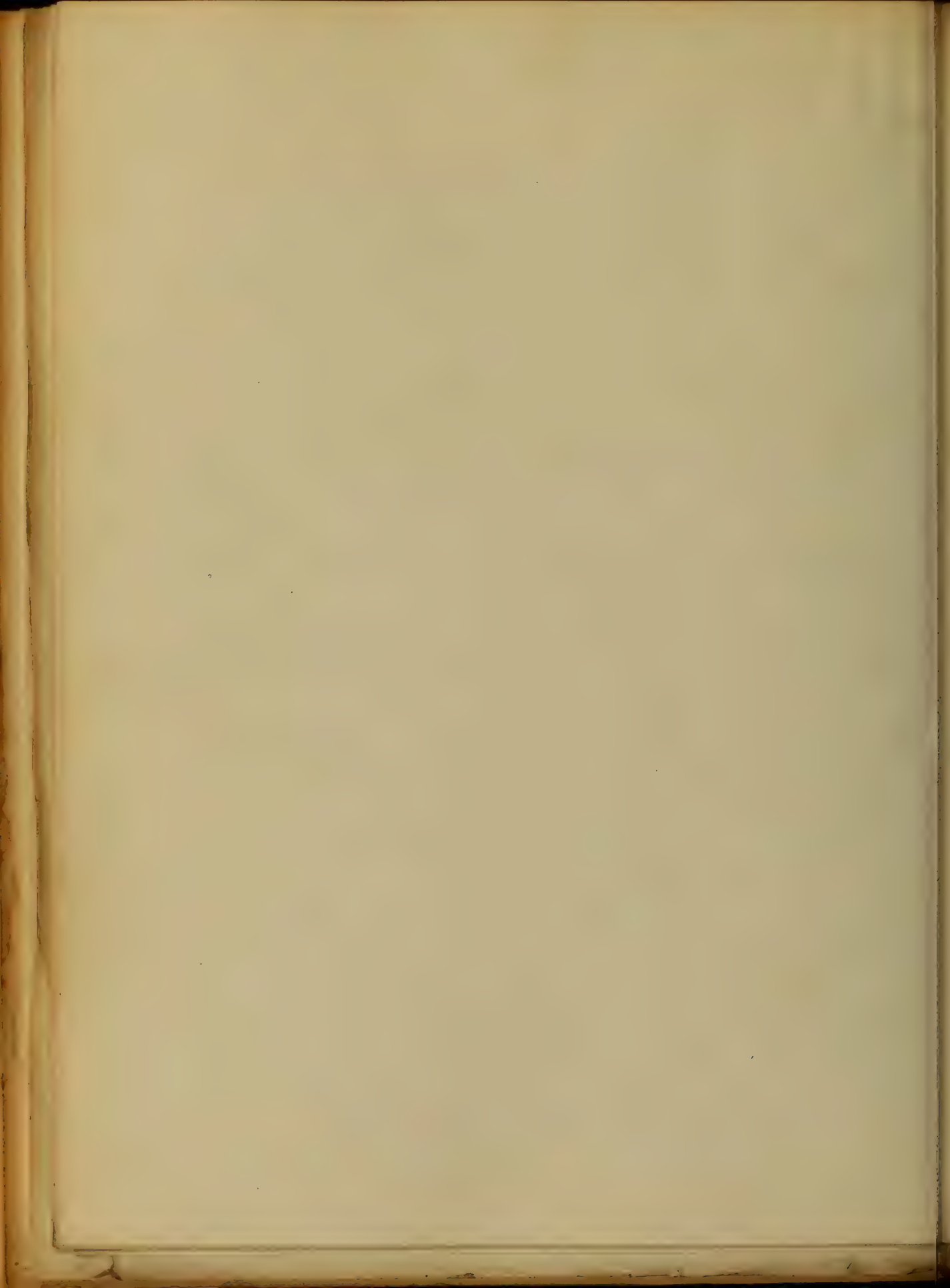


out the...
 distinct...
 of the...
 systems...
 encouraging...
 a part of the...
 in. And so we see anxious parents
 hurry their...
 couples...
 one...
 blameless...
 account...





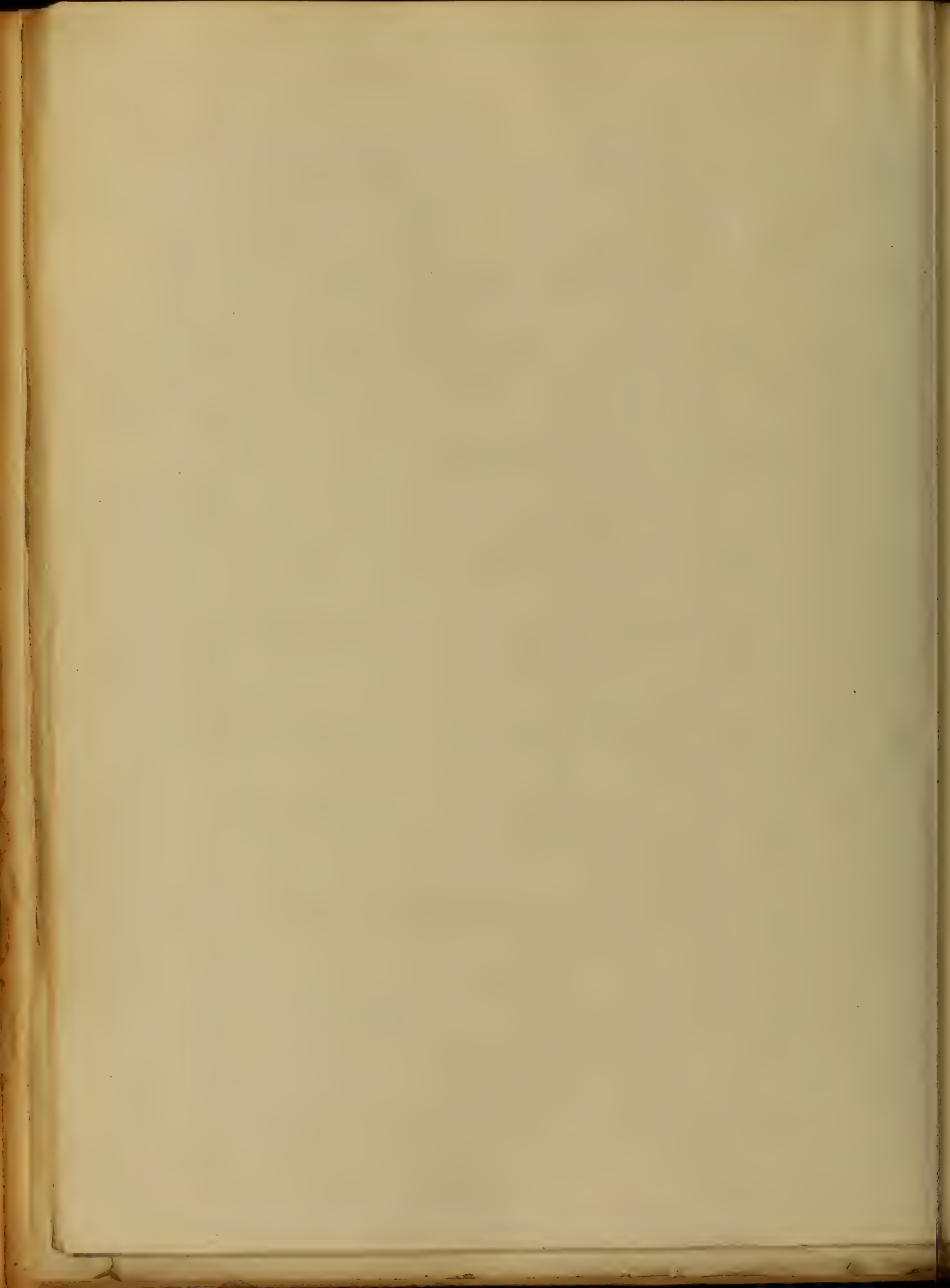




will require a ... and ...
... The ...
... would certainly ...
... have been, ... sharply ...

Schools would become ...
deteriorating influences, and ...
... and ...
... would ...
... to the ...
... the ...
... practical application of ...
... should ...
... into the ...
... of their every day life.

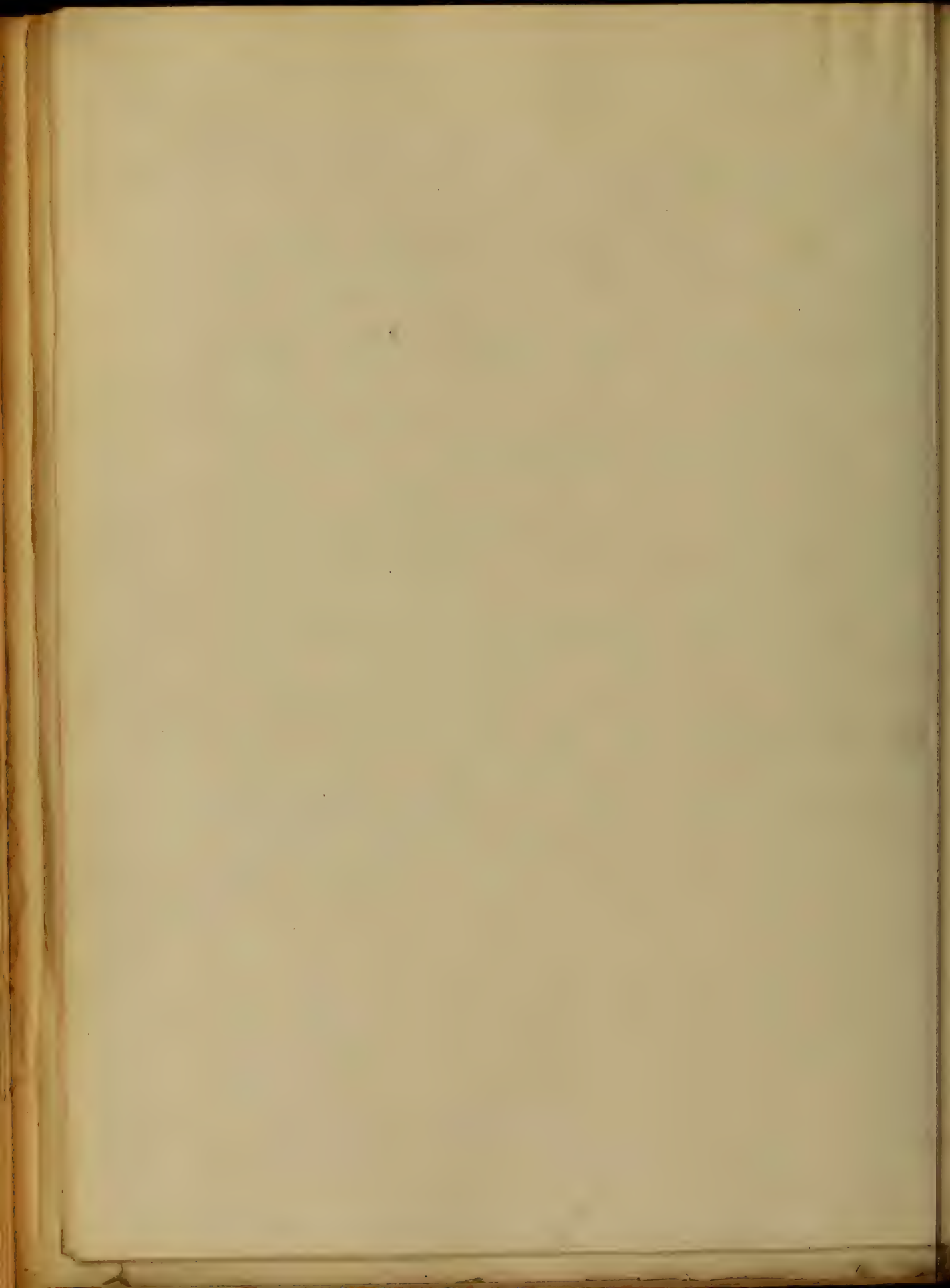
... habits, ...
... would be required, ...
... of fashion, ...



116
I presume, under such circumstances
would be reduced to a minimum.

The people would know how to
eat, what to eat, and where to
eat, as well as how to economize
in preparing their
food; subjects of great importance
but the ignorance of which, may
be said to be almost universal.

The average number of years, con-
sidered man, in consequence of
his own vice, to live, would also
be increased beyond a divination.



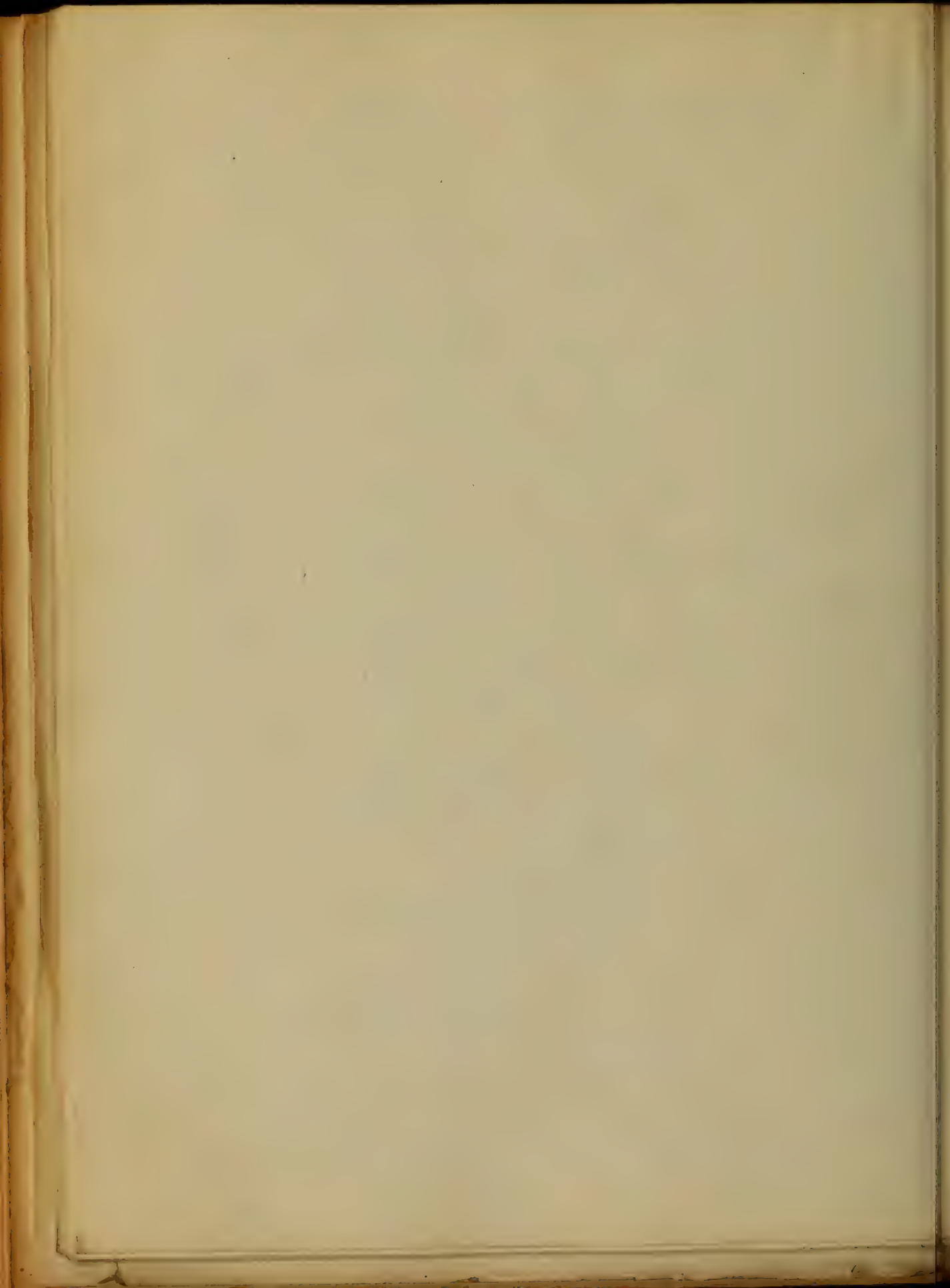
A
Thesis
On

Leukosia of the Liver
Submitted, to the Examination
Of The
Provost, Regents and Faculty
Of Physic of The
University of Maryland
For the degree.

Doctor of Medicine

By
R. H. Wagner.

North Carolina
A. D. 1877

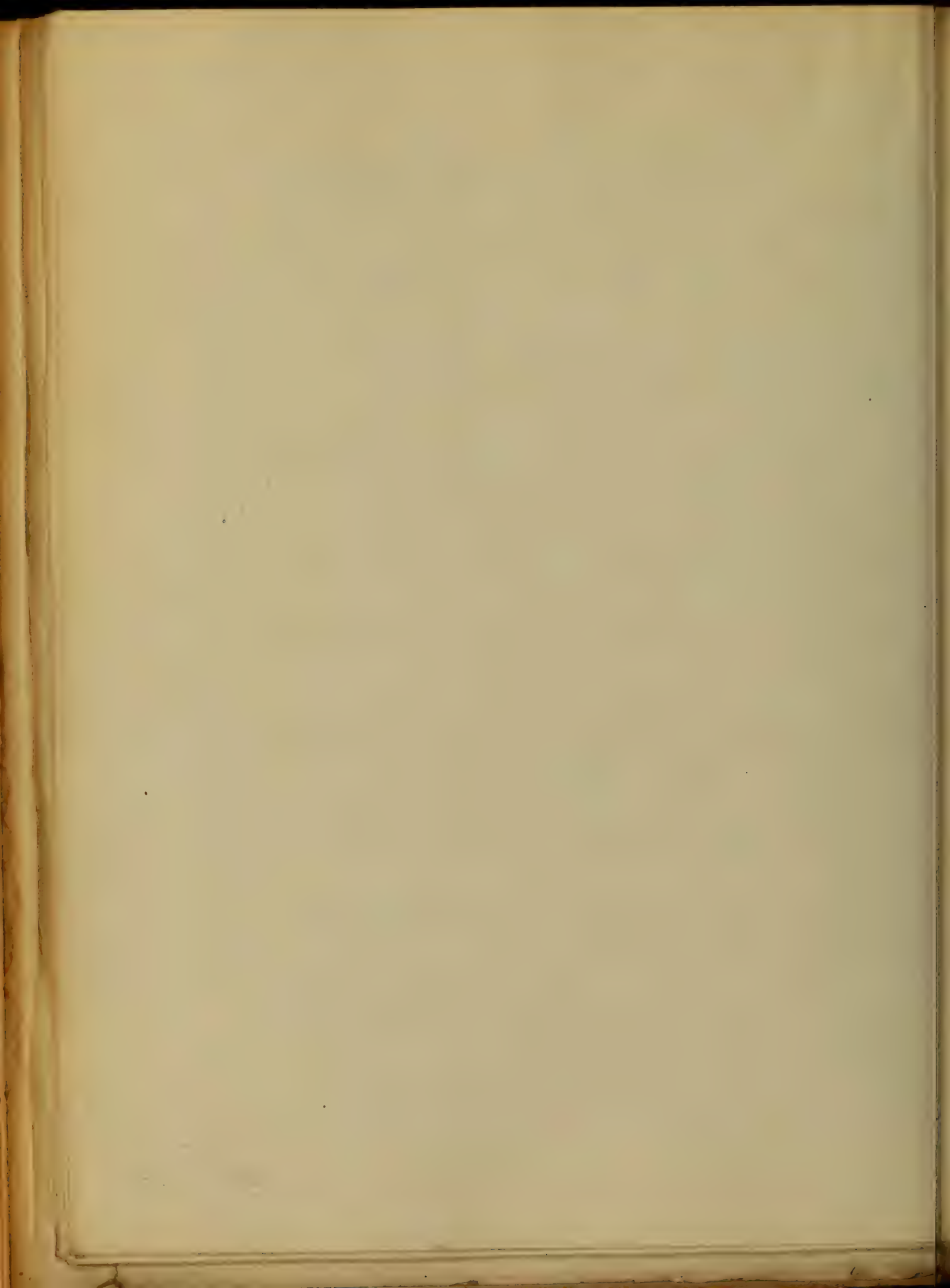


Fibrosis of the Liver

Etiology - Fibrosis of the liver commonly known as nodular liver, is a chronic interstitial hepatitis, which affects the fibrous covering of the liver, and scanty connective tissue, which as a continuation of Glisson's capsule, accompanies the hepatic vessels, and traverses the parenchyma of the liver.

The inflammatory process consist in a proliferation of the above named tissues into new connective tissue.

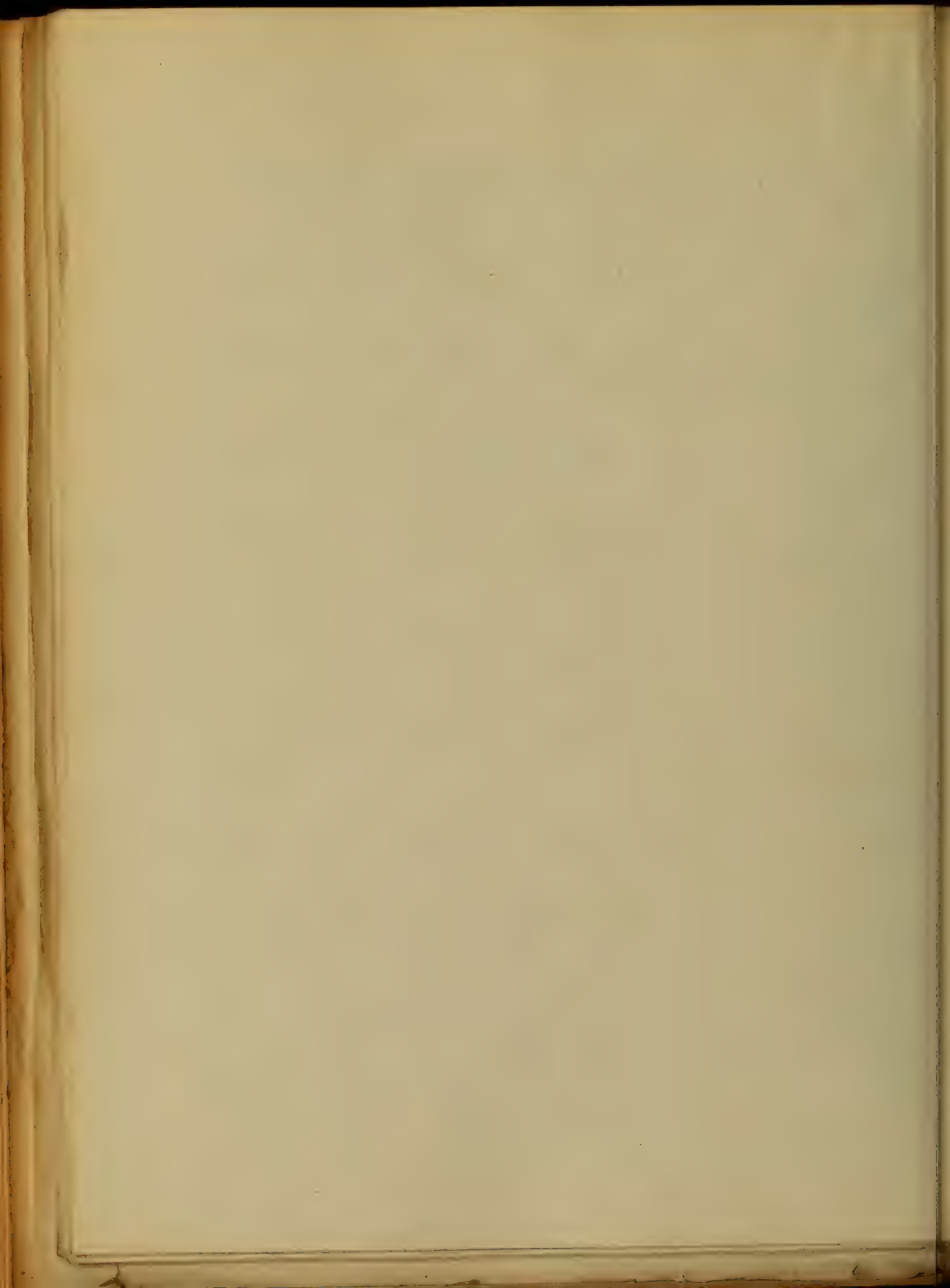
While the new connective tissue increases, the parenchyma becomes more and more displaced. In the later stages of the disease, this new formed



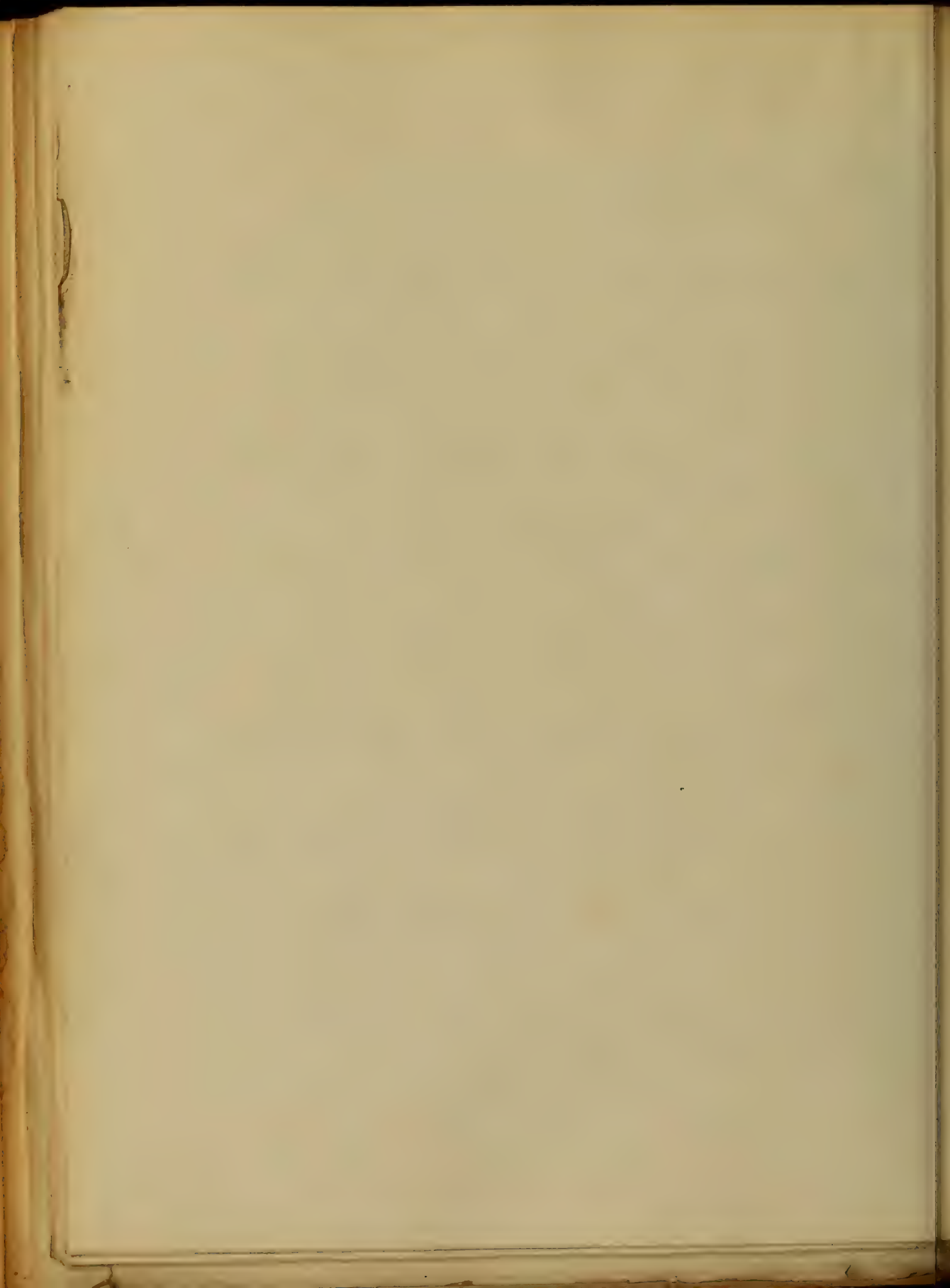
tissue undergoes a circumscribed contraction, which produces sufficient pressure to partly strangulate and partly destroy the parenchyma of the liver.

As the disease advances, the hepatic blood vessels and bile ducts become obstructed and the liver exhibits atrophy. Alcohol is the most frequent cause of chronic hepatitis. In proportion to the extent, which alcohol is used by both sexes, chronic hepatitis occurs more frequent in men than women.

A majority of cases occur after thirty years of age. It is very rare in children. Other causes of chronic hepatitis are very obscure.



of the right lobe is increased.
 In this stage, the organ is covered
 with granular and watery projections.
 The serous tissue between the granules
 is whitish, tendinous, and retracted.
 If the projections separate, large por-
 tions of the liver, it appears lobular.
 The substance of the liver is hard
 and of a rather tough texture. On
 cutting into the liver, we find the
 same granulations, as on the surface.
 At some places, the haemelytra
 has completely disappeared. The still
 existing liver cells, have partly un-
 dergone degeneration, and partly
 intensely yellow, as a result of
 retained bile. The fatty degeneration

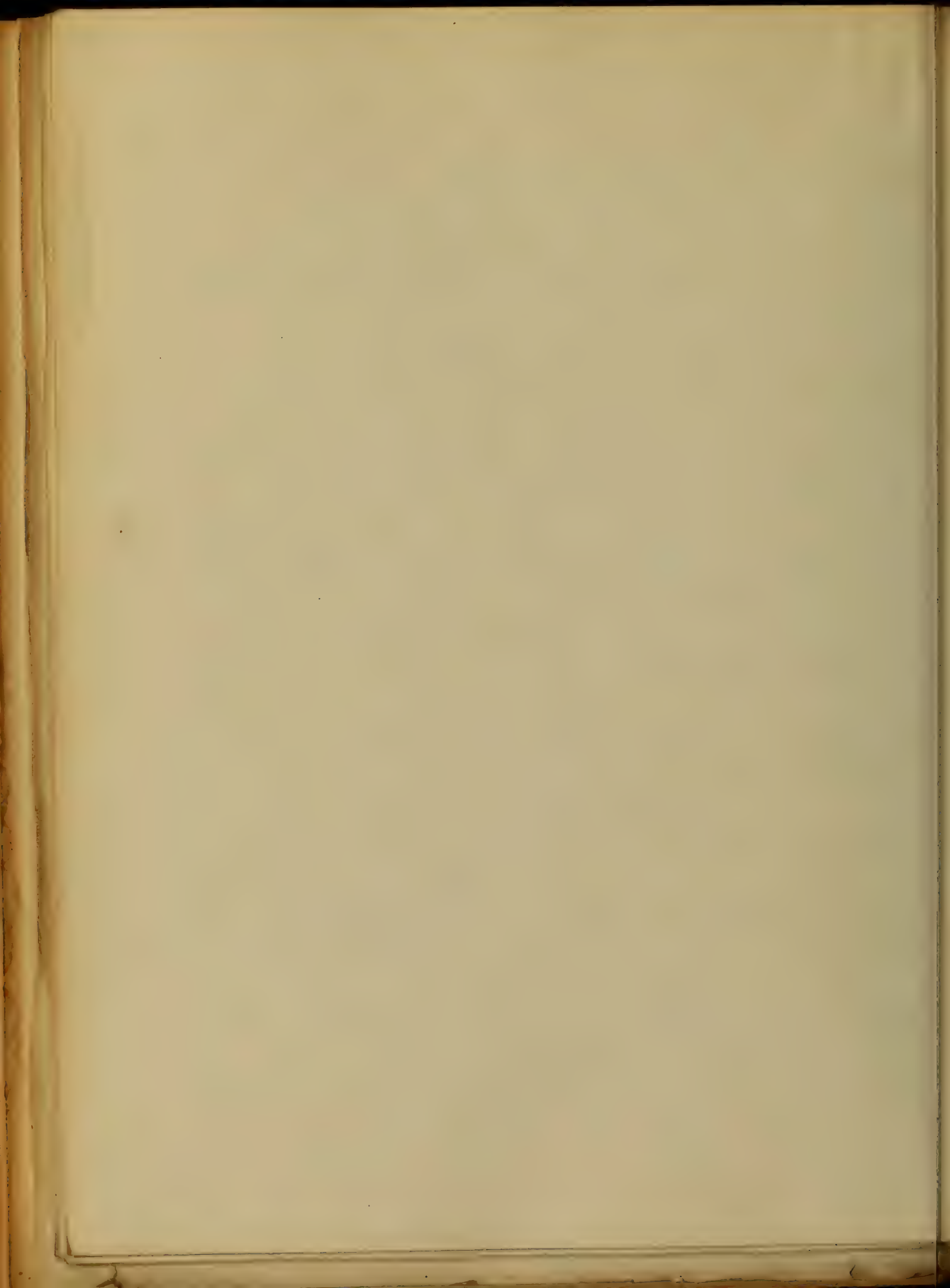


of the liver cells, and the retained bile, give the entire liver a yellow color, to which it gives name. "Icterus".

Symptoms and Course.

During the first stage, the inflammatory process goes on within the liver and its neighbourhood, and is usually attended with little pain; but sometimes the fulness in the hepatic region increases to intense and burning pain.

Patients generally complain of anorexia; and feeling of fulness and heaviness after eating. They complain of flatulence, and constipation. Their nutrition becomes impaired; and they have a

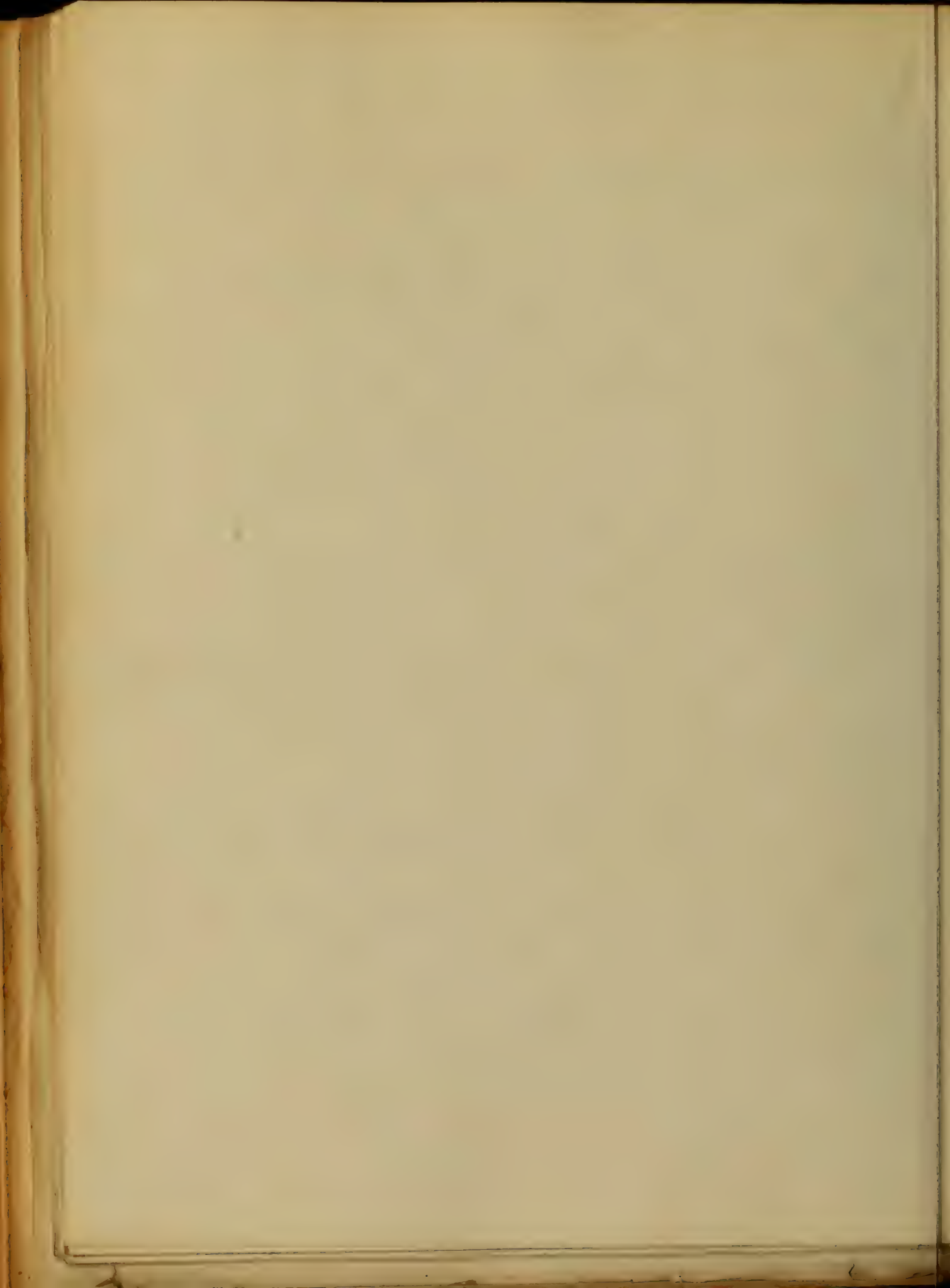


cachetic appearance. These conditions may occur in various other diseases.

In the second stage, the symptoms depend almost entirely upon mechanical conditions. Compression of the branches of the portal vein must cause congestion of other organs, from which it conducts the blood to the liver; compression of the bile ducts will cause absorption of bile, icterus &c.

Symptoms of congestion occur generally first in the gastric and intestinal mucous membranes.

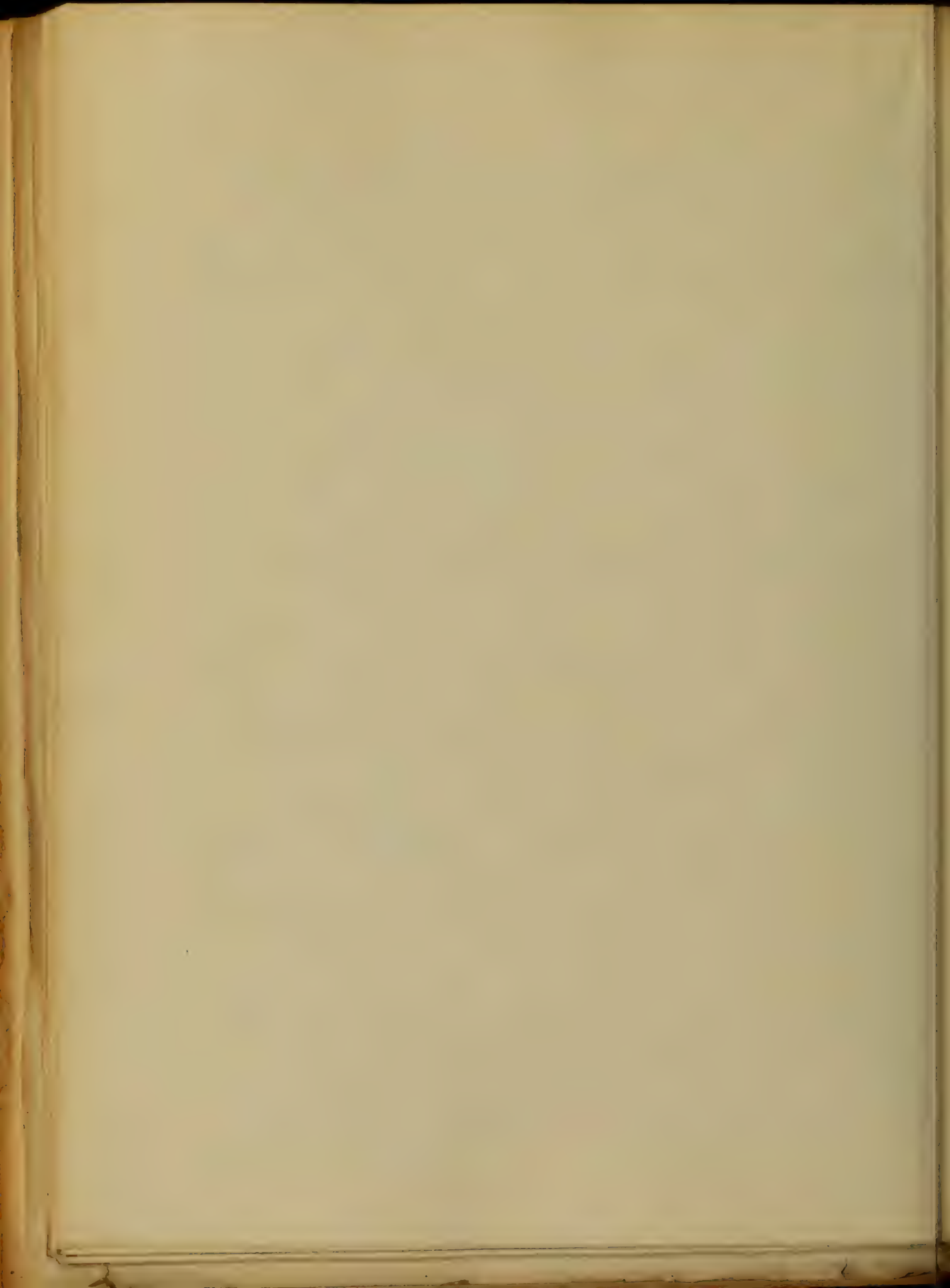
The intestinal inflammation rarely leads to excessive transudation of fluid into the intestines, but to



a copious production of cells and a secretion of tough mucus. Owing to the obstruction of the portal circulation, the capillaries of the stomach and intestines become so much distended, as to rupture. Hence *hemorrhoids* of the liver, like ulcers of the stomach may cause gastric and intestinal hemorrhages.

The impeded portal circulation by overflowing of the inferior mesenteric artery, and haemorrhoidal plexus, causes the formation of *haemorrhoids*, which are of frequent occurrence in *hemorrhoids* of the liver.

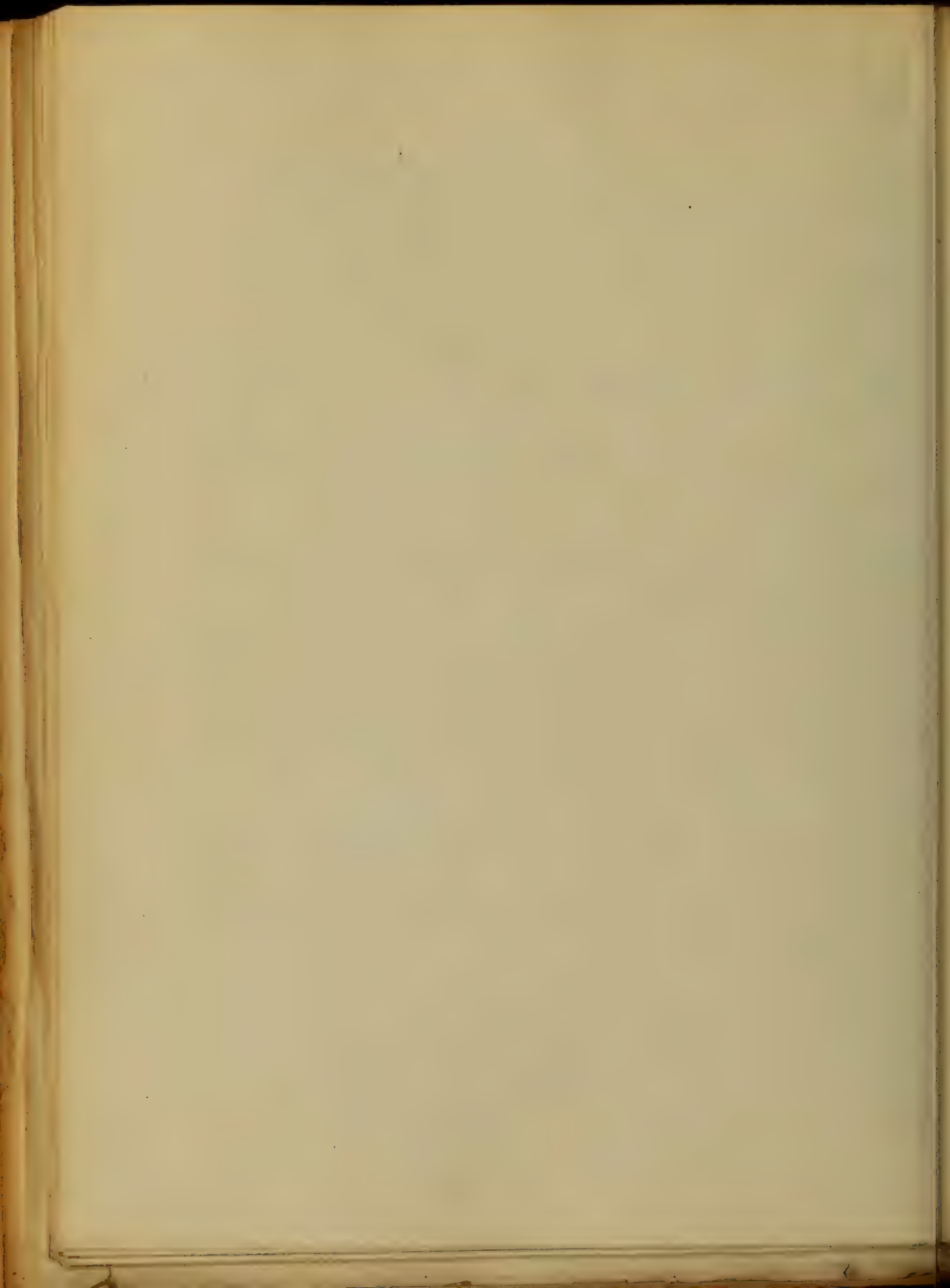
The splenic vein empties into the portal vein, and compression



of its branches, cause enlarge-
ment of the Spleen; but observa-
tions have shown; that that is not
the only cause of enlargement of
the Spleen. Probably it may be due
to a process similar to that of swelling
the liver.

When enlargement of the Spleen
is due to portal obstruction, it always
diminishes in size after haematem-
sis from rupture of the capillaries
of the stomach.

As all of the hepatic veins, and
especially those of the visceral folds,
empty into the portal vein, we
may easily understand, how
ascites can occur. The ascites

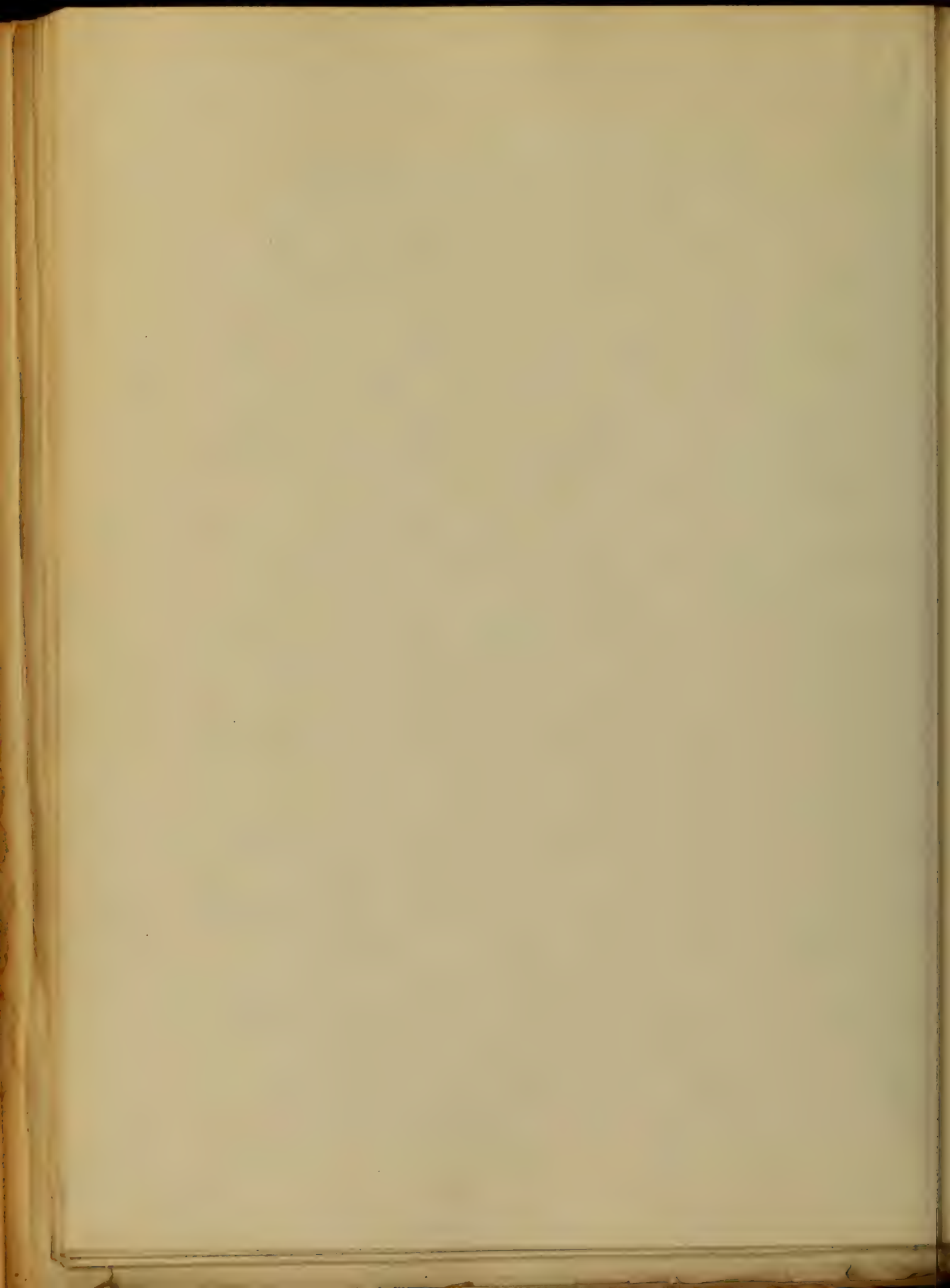


occurs entirely by a mechanical
 force, the abdominal veins by
 'becoming' compressed, produce
 sufficient pressure in the veins to
 cause a transudation of the serum
 of the blood, through their walls
 into the abdominal cavity.

Ascites, which forms a symptom
 of cirrhosis is usually very extensive,
 and it is this form of ascite.

That the blue veins of the abdomen
 are distinctly shown.

The dropsy which attends first
 in the abdomen, as all other cases
 do that depend upon abdominal
 trouble, gradually descends into the
 genital organs and lower ex

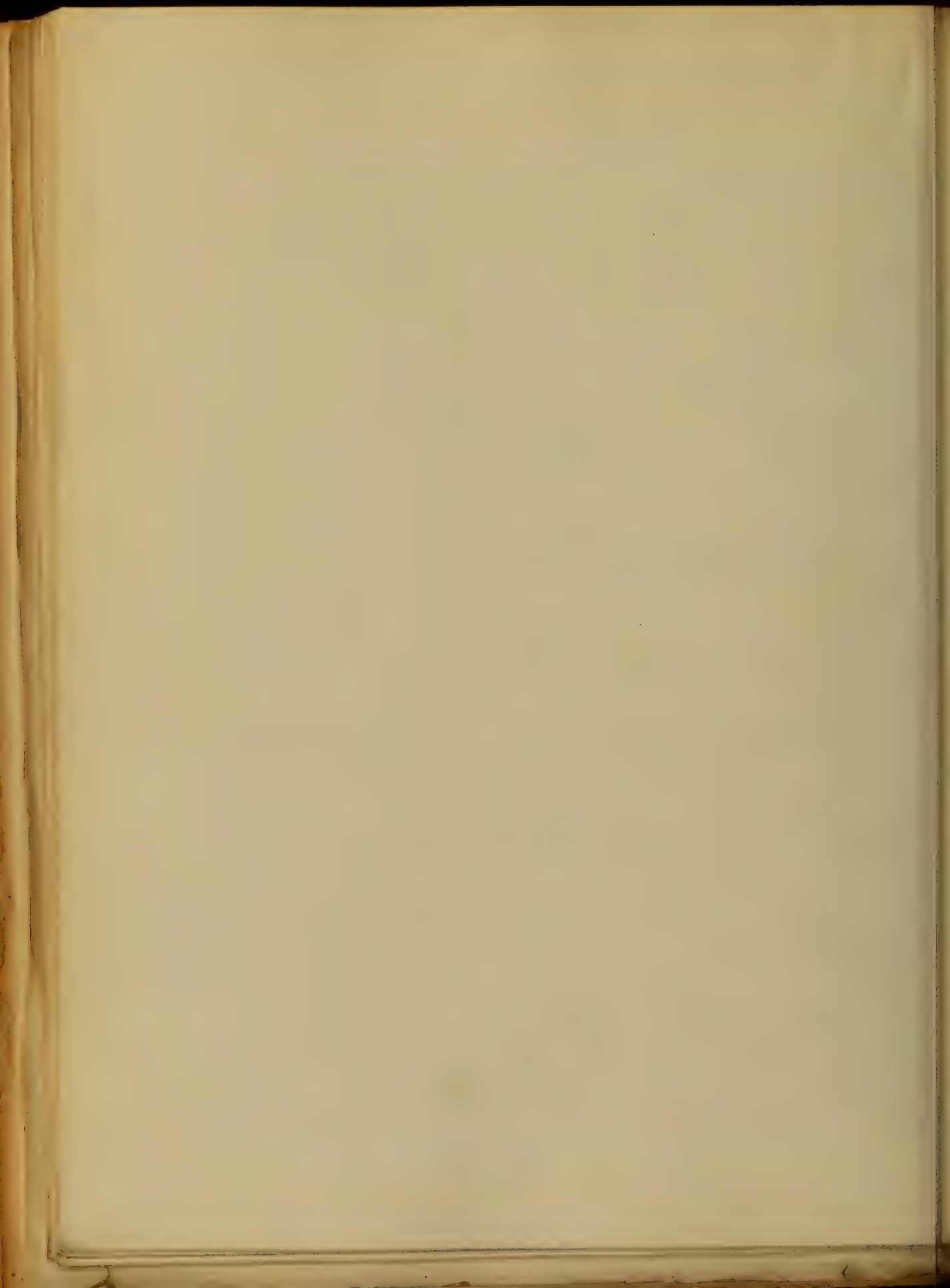


hemorrhoids.

In some very rare cases haemorrhoids, enlarged spleen, and ascites are wanting. These conditions have been explained by supposing that collateral circulation had been developed. This theory I will not undertake to explain.

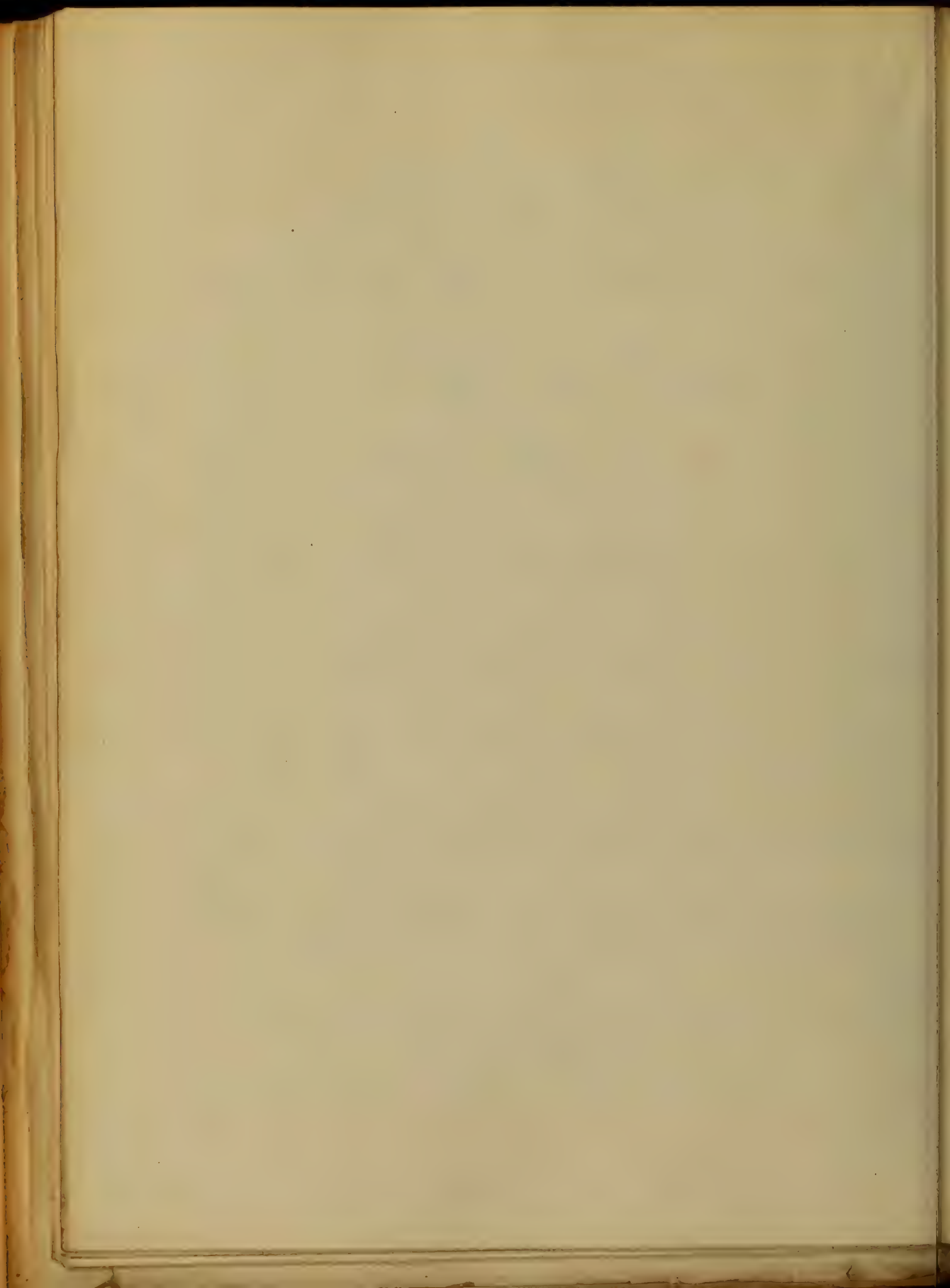
There is rarely very much bilious obstruction or intense icterus. It is cirrhosis of the liver, although the bile ducts are subjected to the same pressure as the portal veins.

The dirty coloring of patients, light colored urine and slight icterus have been explained by the physiology of the bile. The blood



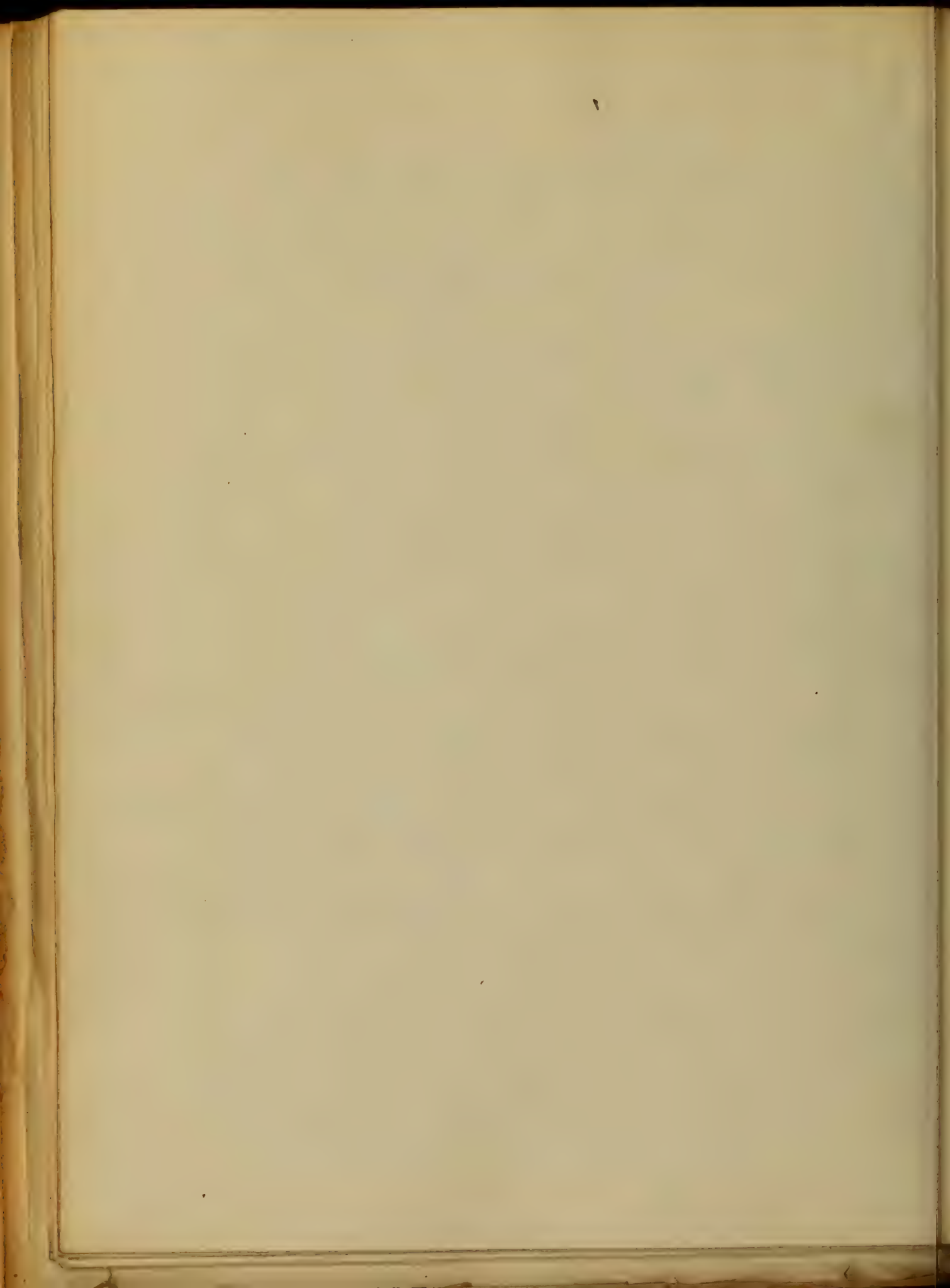
going to the liver contains no bile,
 but it is reformed there from the
 material supplied by the blood. Hence
 obstruction and absorption of bile
 show that part of the liver cells
 are there and act normally.

Biliary compression induces condi-
 tions, which usually leads to obstruc-
 tion and absorption of bile, and
 destruction of liver cells leads to for-
 mation of a limited quantity of
 bile. We can now see, why icterus
 is hardly ever absent and rarely at-
 tains a high degree. Usually a high
 grade of icterus is an indication
 that compression of the bile ducts
 is in excess, a slight degree of icterus



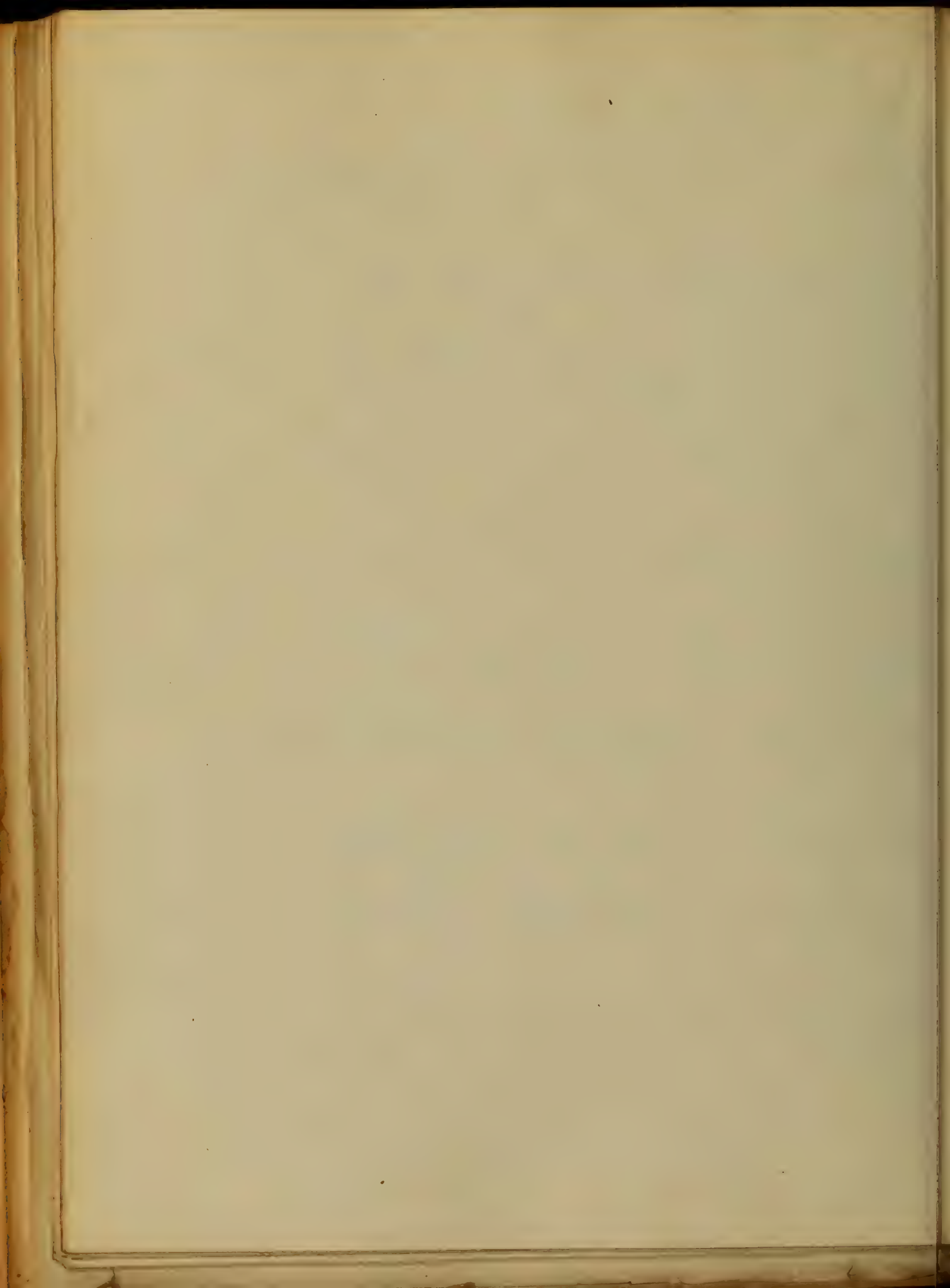
is an indication that destruction of the liver cells prevails. If the flow of bile be entirely prevented, the few remaining liver cells, will be sufficient to produce intense icterus. This gray-colored stools depends usually upon biliary compression and sometimes upon destruction of liver cells.

The urine in catarrh of the liver contains bile pigment, and is remarkable for its richness in matter and peculiar coloring matter. However has yet shown what causes these conditions of the urine. In some rare cases just before death the patient falls into delirium.



and usually ends in death. Post-mortem examinations have shown no palpable changes to account for these brain symptoms; hence they are attributed to intoxications. Some say they depend upon choleric intoxications; others say they depend not so much upon choleraemia as they do upon aetiology. Physical sign - Inspection only shows a visible enlargement of the superficial veins.

Percussion - In the first stage, the normal hepatic flatness is increased; in the second stage it is diminished. The hepatic flatness instead of extending to the free border

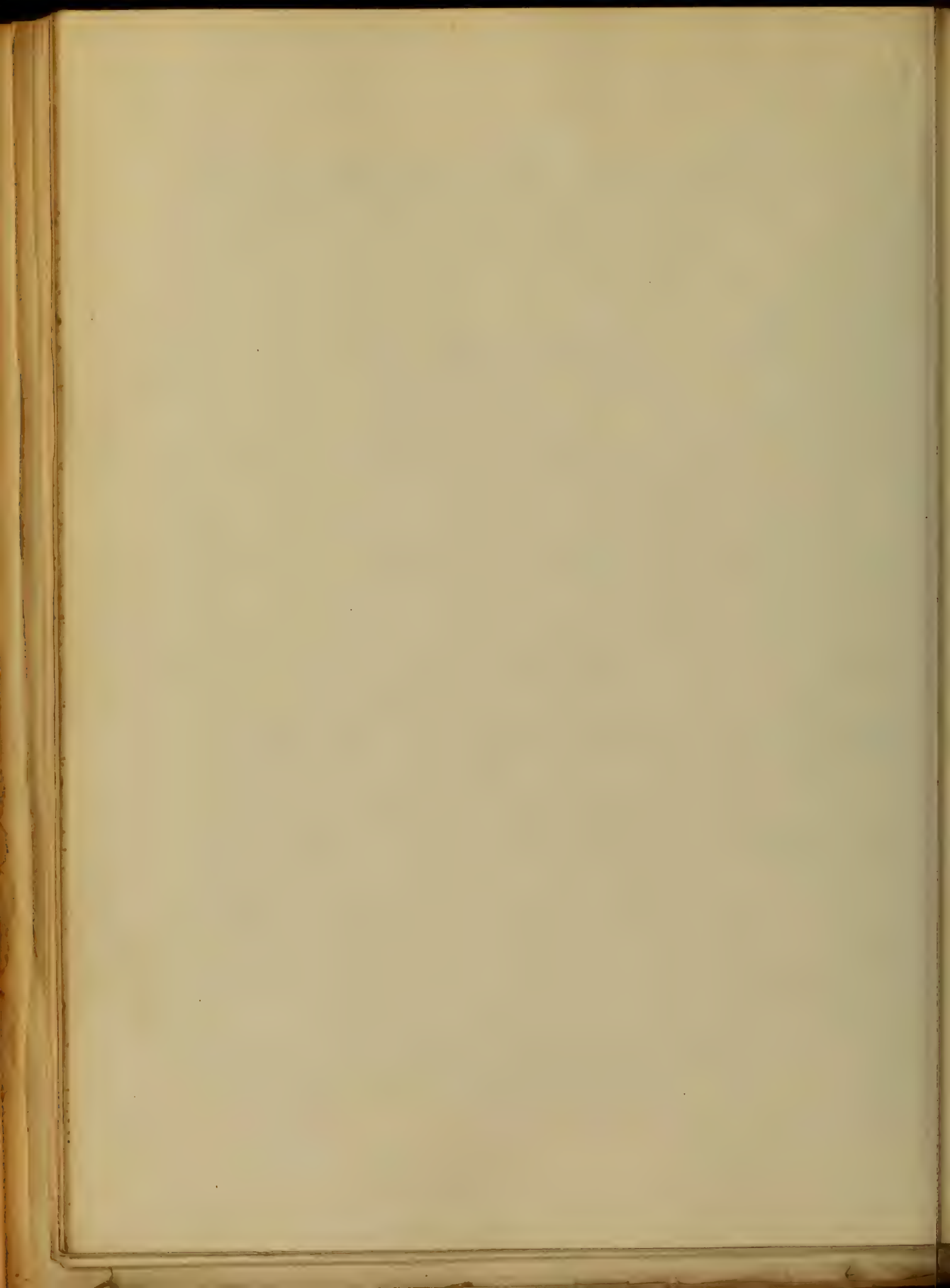


of the ribs, give place to lymphatic resonance, an inch or two above their margin.

Palpation. By pressing with the fingers upwards and upwards, small nodules can be felt on the surface of the liver. Sometimes they can not be felt until paracentesis has been performed.

Diagnosis. Cirrhosis may be suspected from certain habits of the patient, such as intemperance. It is often difficult to make a diagnosis between cirrhosis and cancer of the liver, or tuberculosis of the peritoneum.

In cancer of the liver, the patient

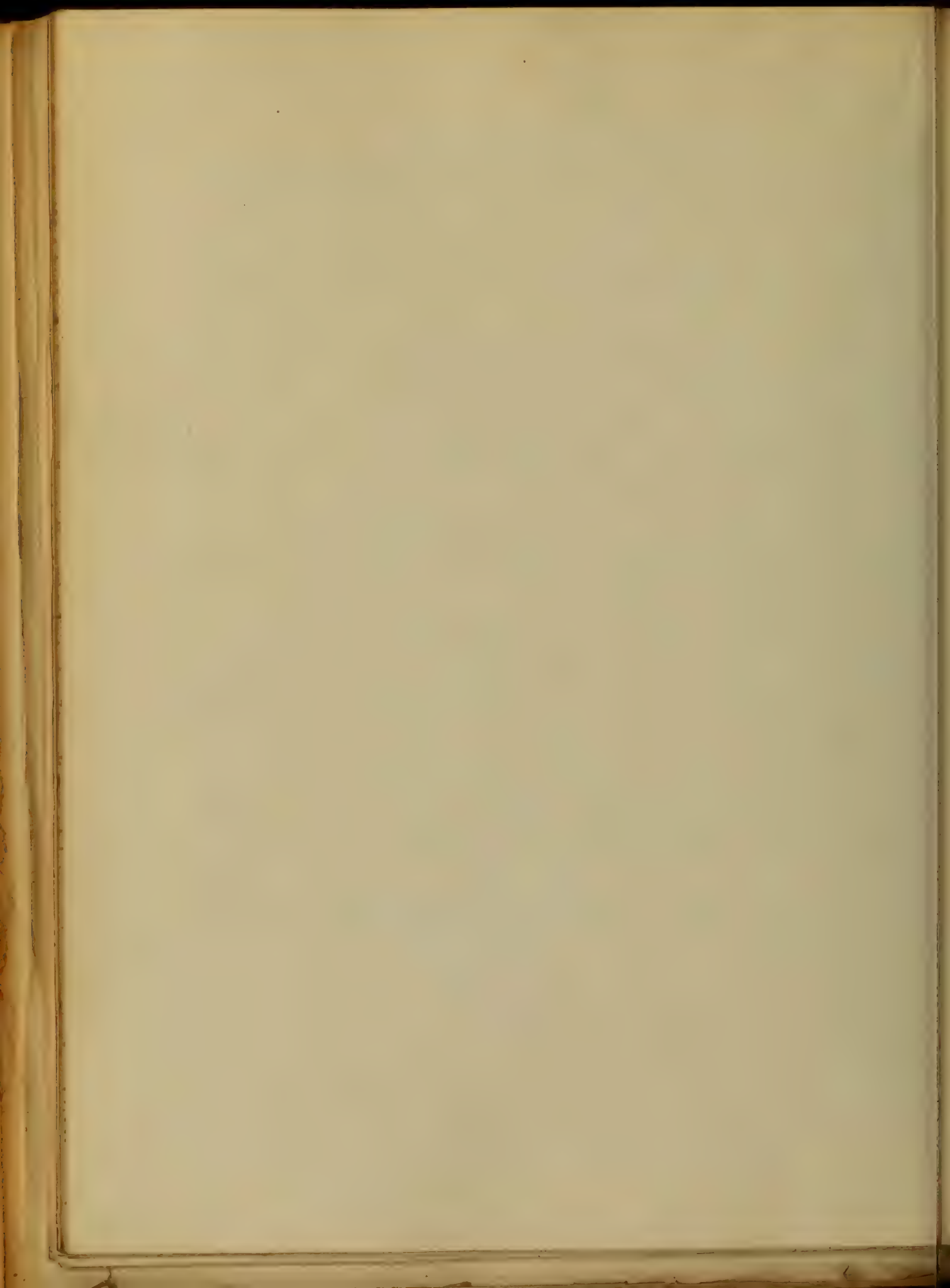


Becomes very much emaciated and cachectic; the tumor may become so large as to compress the ductus choledochus and cause intense icterus.

Lymphosis may be suspected, 1st when there is enlargement of the spleen and when there are quantities of coloring matter and urates in the urine, 2d when the patient has been given to drinking spirituous liquors.

Cancer may be suspected 1st when it has been recognized in other organs, 2nd when the patient has a dirty yellow appearance, known as the 'cancerous' taint.

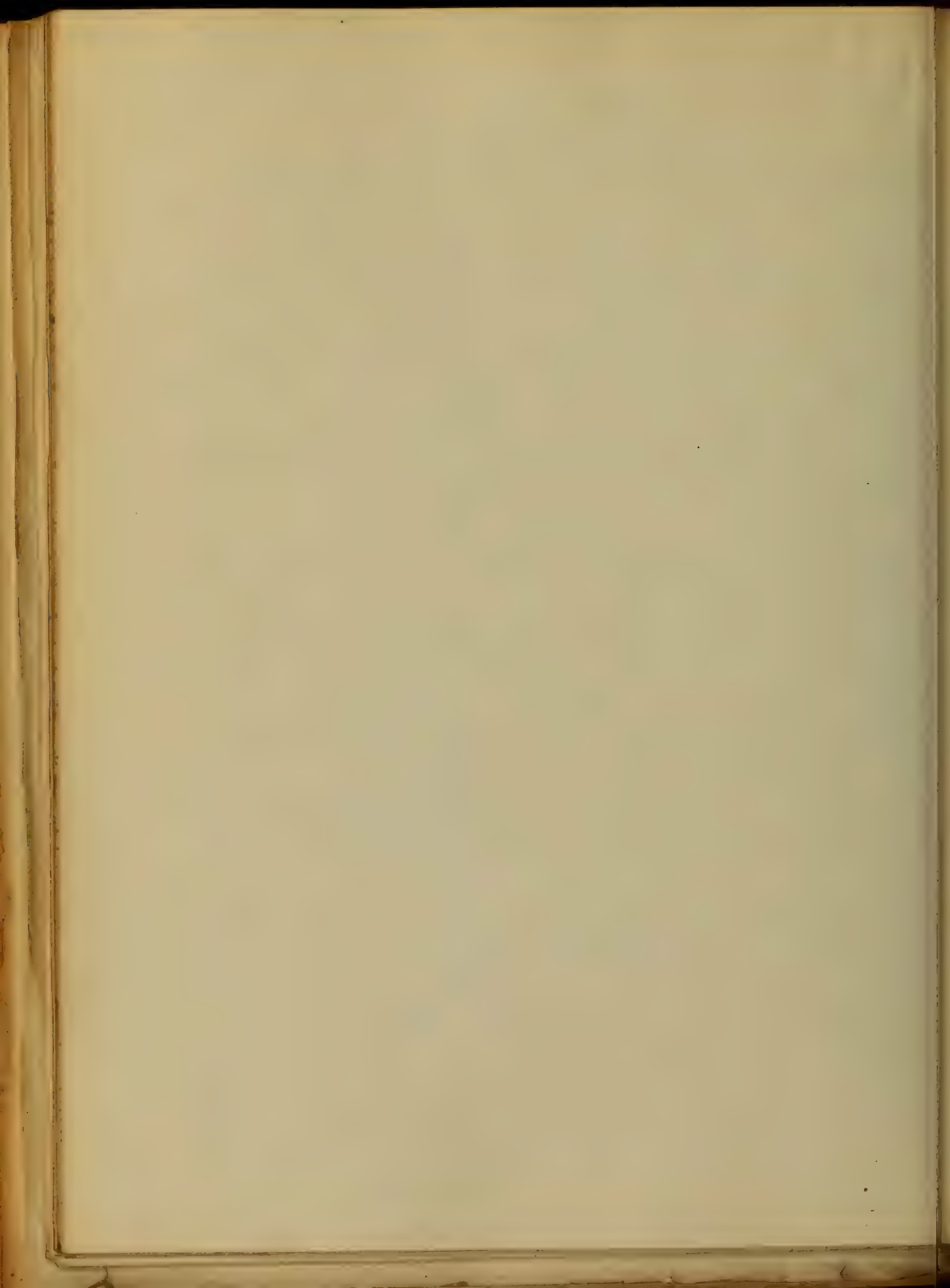
When the abdomen is very sensitive



to measure, and there is rapid loss of strength, rapid development of ascites, occurrence of fibrin in the serousal fluid, which coagulates very slow etc, degeneration of the peritoneum may be suspected.

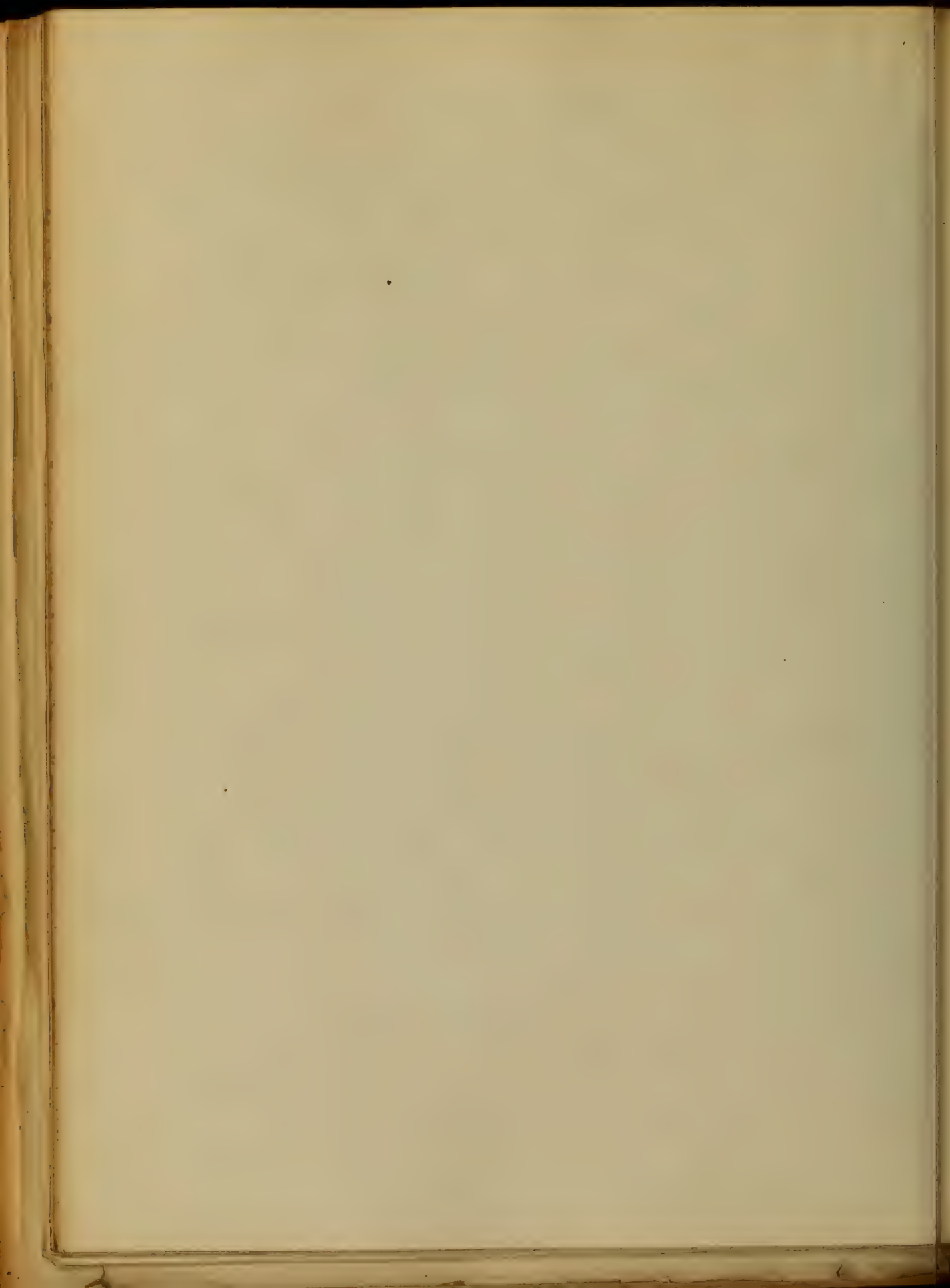
Prognosis. - As regards to a cure is always unfavorable in the second stage. The disease may be arrested in the first stage. In the second stage patients usually live not more than three or four years. (A great many die in three or four months.)

Treatment. - If the disease can be recognized in the first stage, we may hope to arrest it, by prohibiting



the use of any kind of stimulant
 agents. If the patient complains
 of much fulness in the rectum,
 require the administration of saline
 laxatives and, application of
 leeches around the anus may
 prove very beneficial. If the nutri-
 tion of the patient has suffered
 much, tonics such as the preparations
 of iron may be given.

When the disease has reached the
 second stage, we can no longer
 hope to arrest the disease, as the
 neoplastic tissue has undergone
 necrotic, contraction and de-
 struction of liver cells, therefore
 we can only treat the symptoms

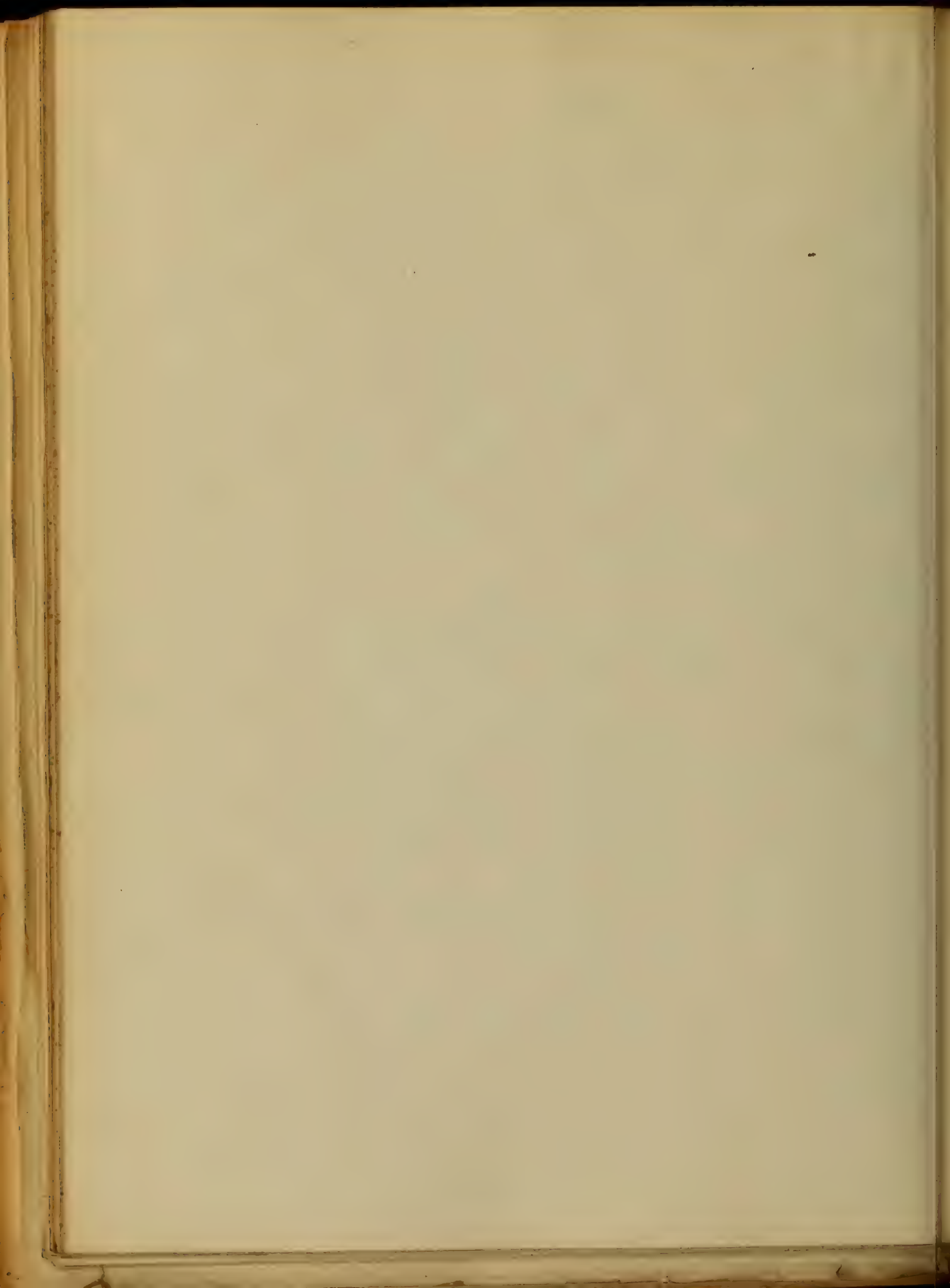


and complications.

The most important indications for treatment in cirrhosis of the liver, is to improve the nutrition and strength of the patient. So long as the digestive organs will permit, the patient should have nutritious food, tonics, etc.

The gastric and intestinal inflammations demand particular attention, as they increase the emaciation and debility of the patient.

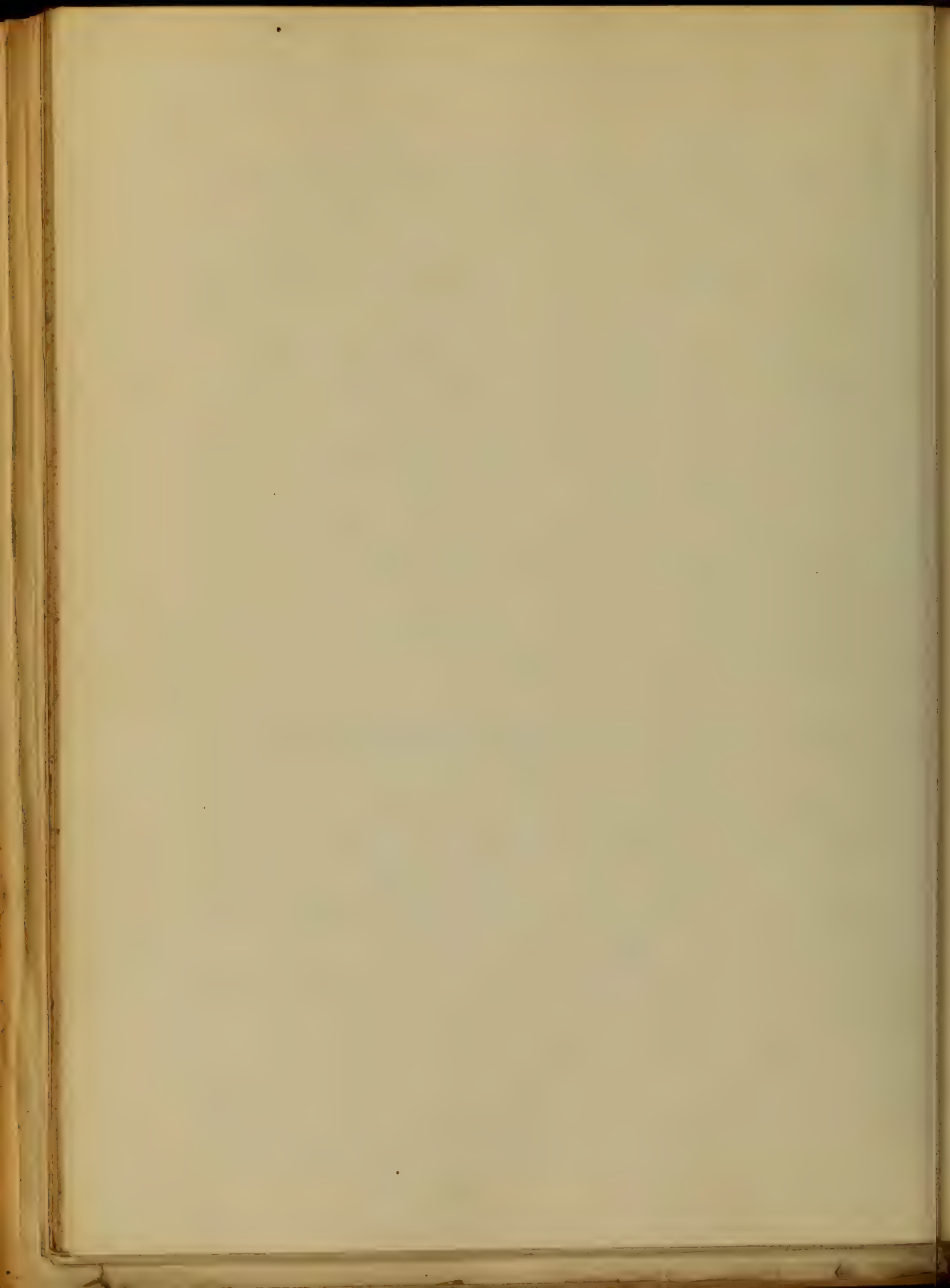
The alkaline carbonates may be the most beneficial, as they tend to decrease the toughness of the muscles, and in this way enable



the mucous membrane to get rid of its mucus coat more readily. The gastric and intestinal hemorrhages may be arrested by the application of leeches around the anus to remove the congestion, cold applications, over the epigastric region, and administration of astringents, such as dilute sulphuric acid, alum, etc.

For the removal of the dropsical accumulating diastolic catarrhes and purgatives should be employed. Professor W. S. Howard recommends the following prescription.

R



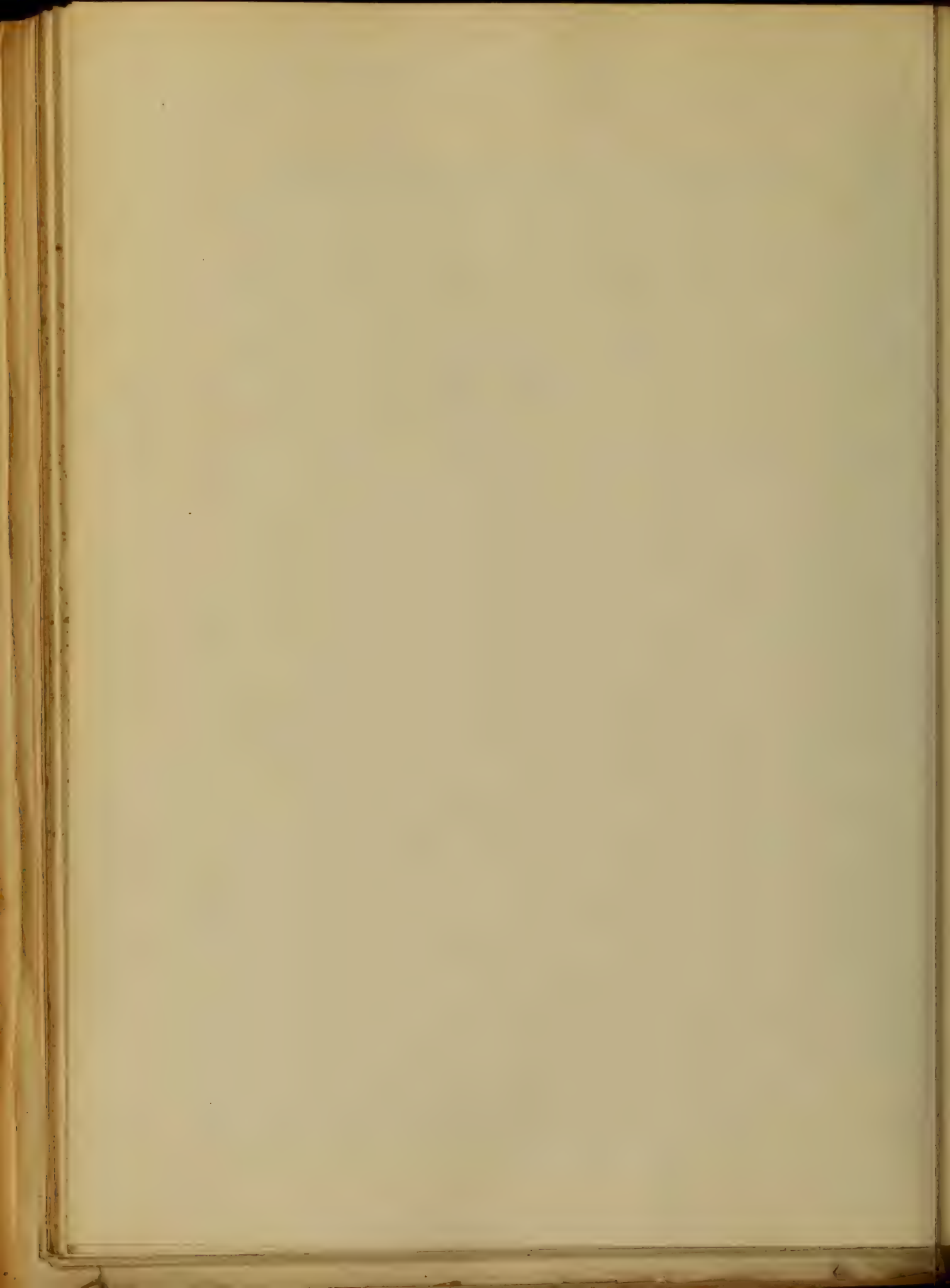
Extract Hyoscyamus gr $\text{ʒ} \text{ij}$

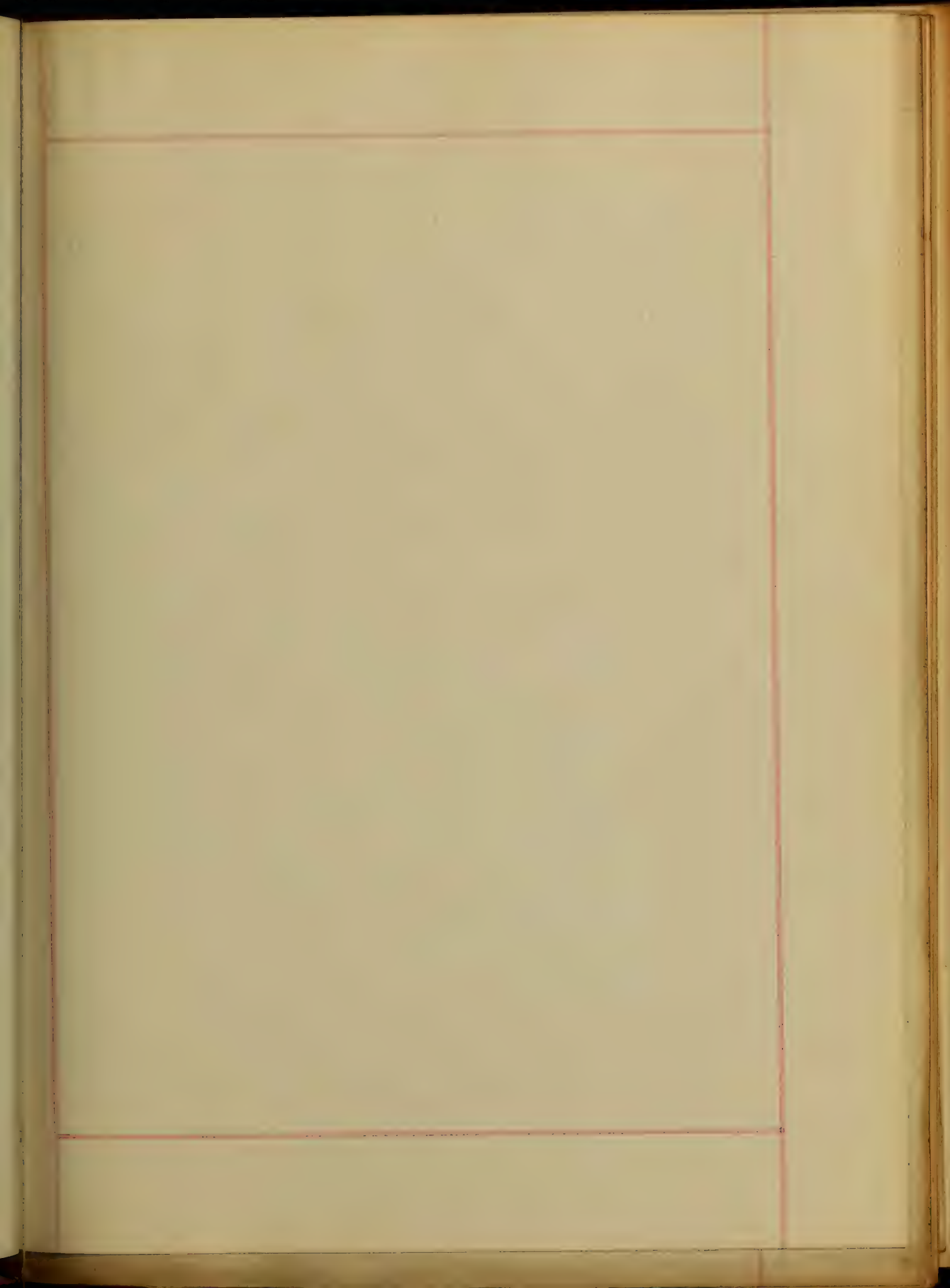
Pulv. Capsicum gr xij

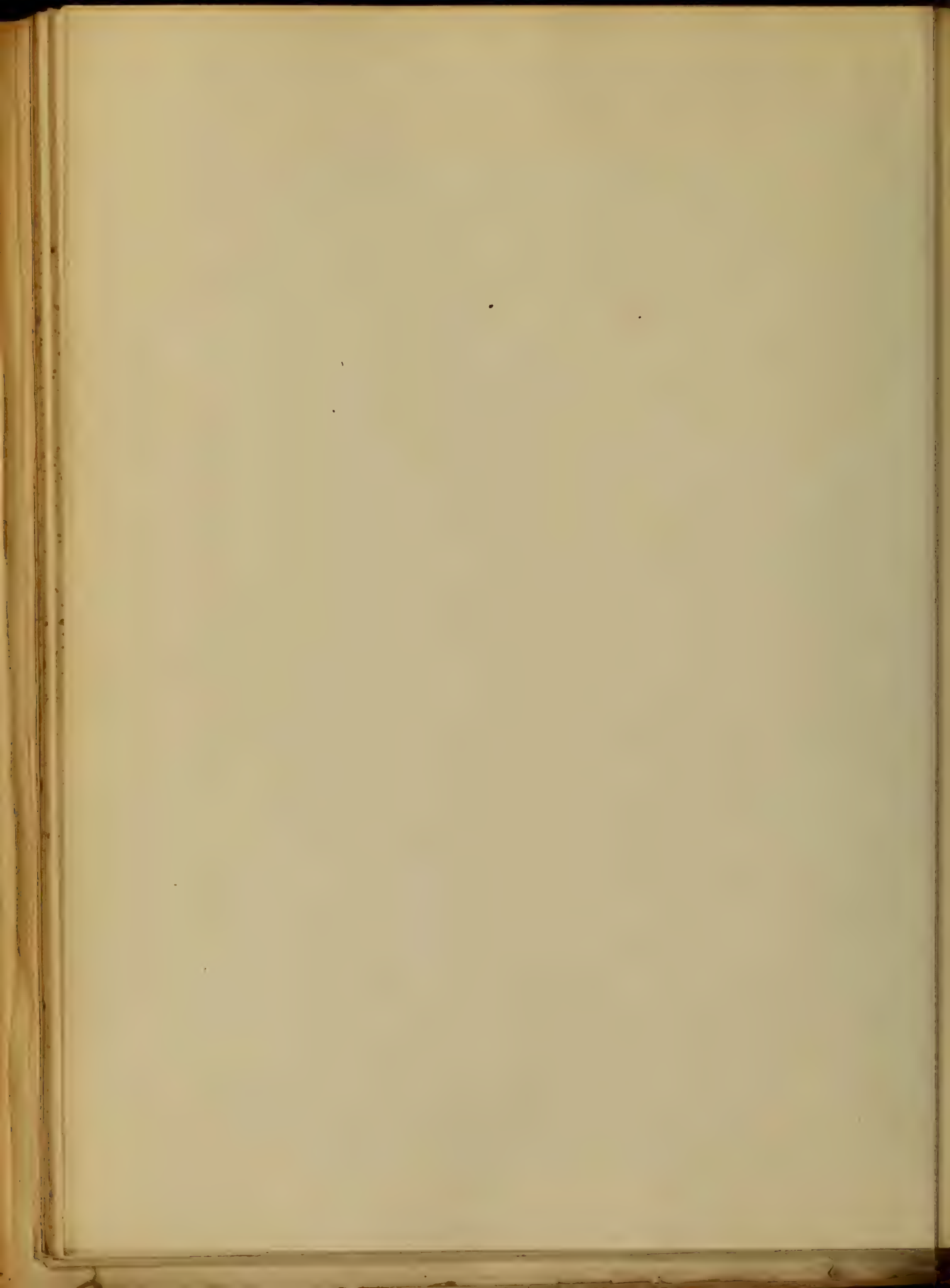
Pulv. Elaterium gr $\text{ʒ} \text{ij}$

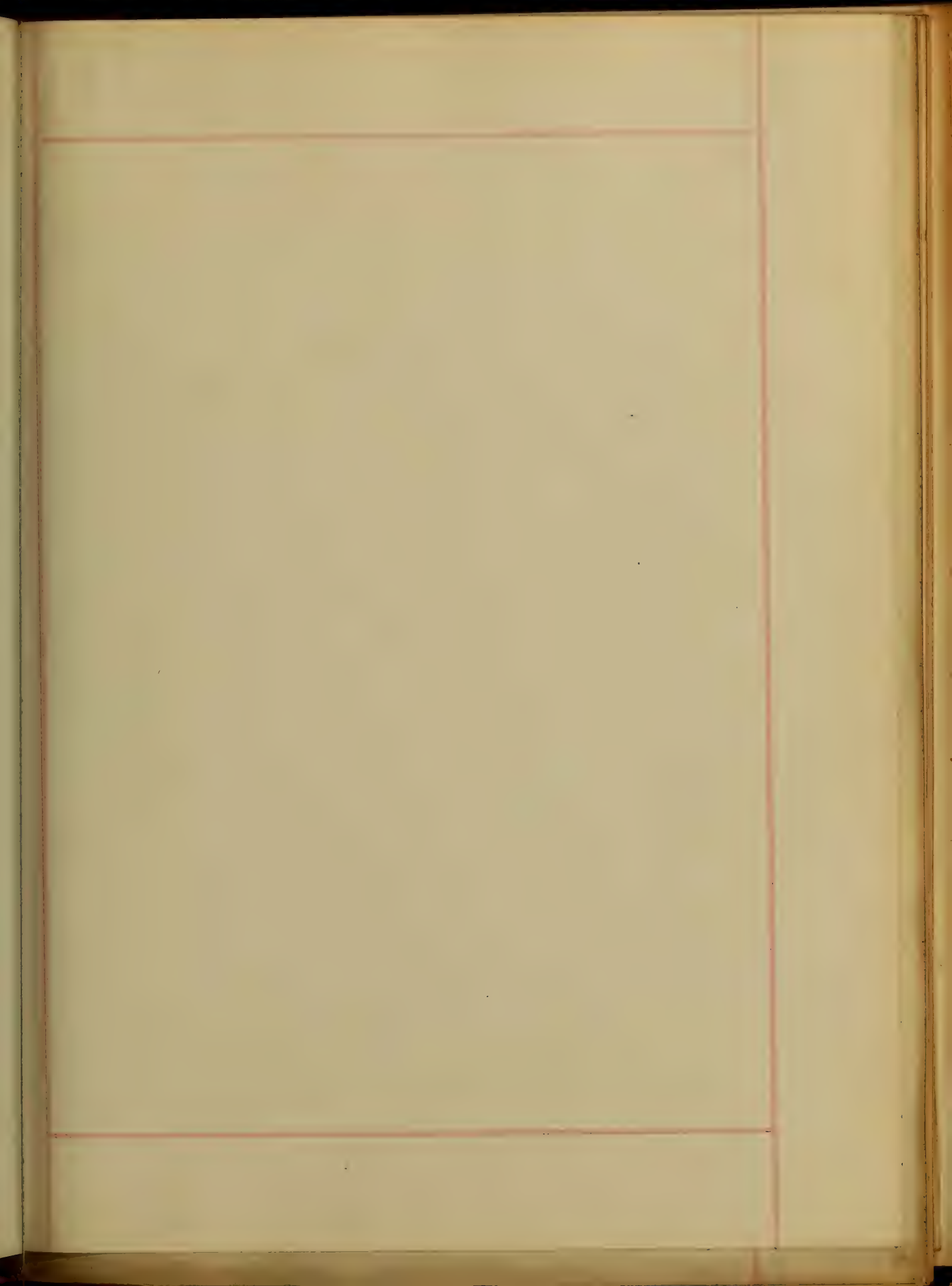
℞ Pills no xij . Sig Take one pill every four hours and gradually diminish the dose according to its exhausting effects. The Hyoscyamus is used to allay the griping action of the Elaterium, Capsicum employed to prevent nausea, and Elaterium used for its cathartic action. I have seen this prescription prove very beneficial in two cases of anasarca, that were in the hospital during Professor W. S. Howard's term. One of the cases depended upon cirrhosis of the liver, and

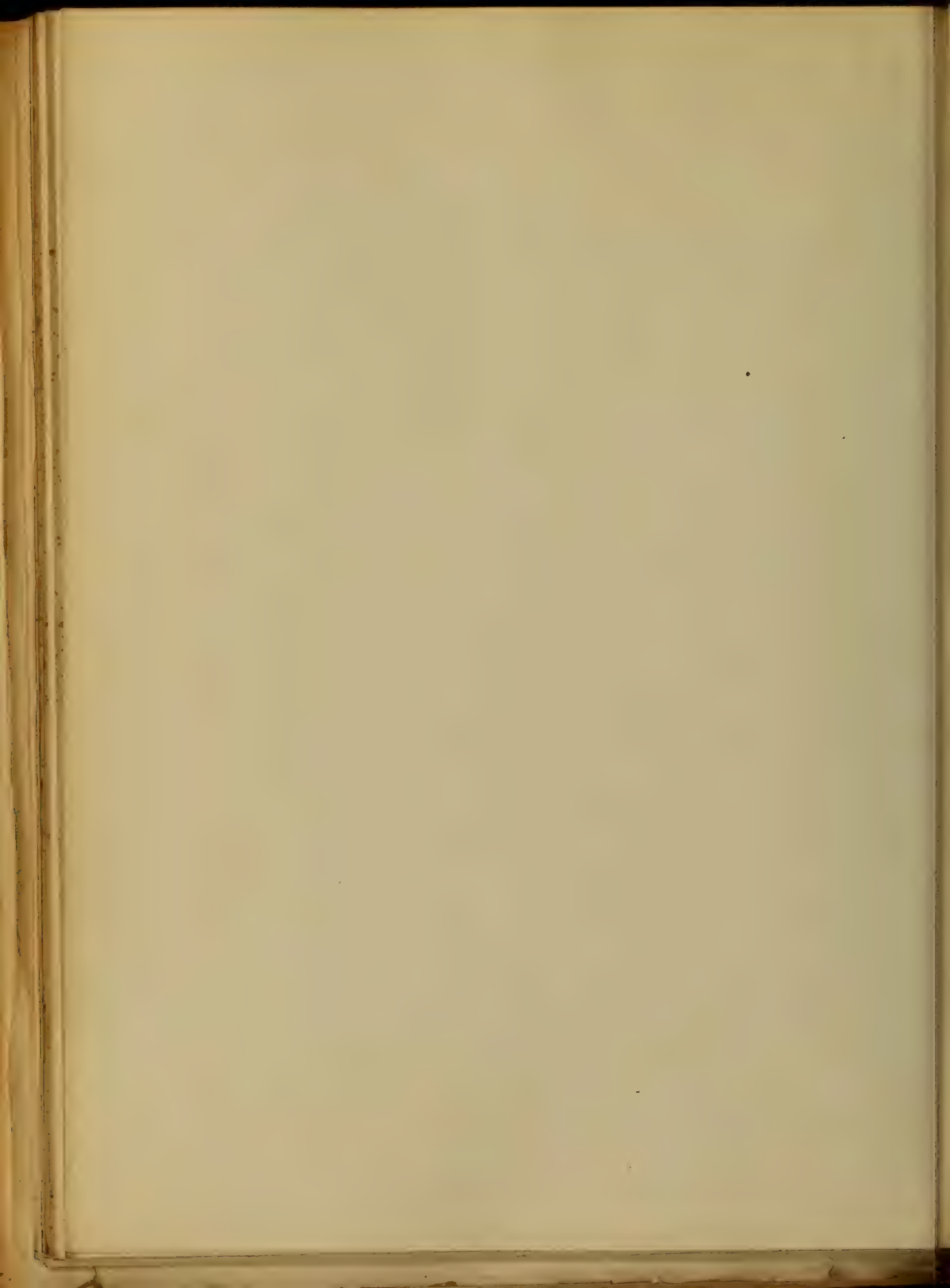
the other upon acute Bright's disease,
If these remedies fail to remove the
droppical fluid, and it is imperative-
ly necessary that the fluid should be
withdrawn, we must tap the patient,
as the last resort.

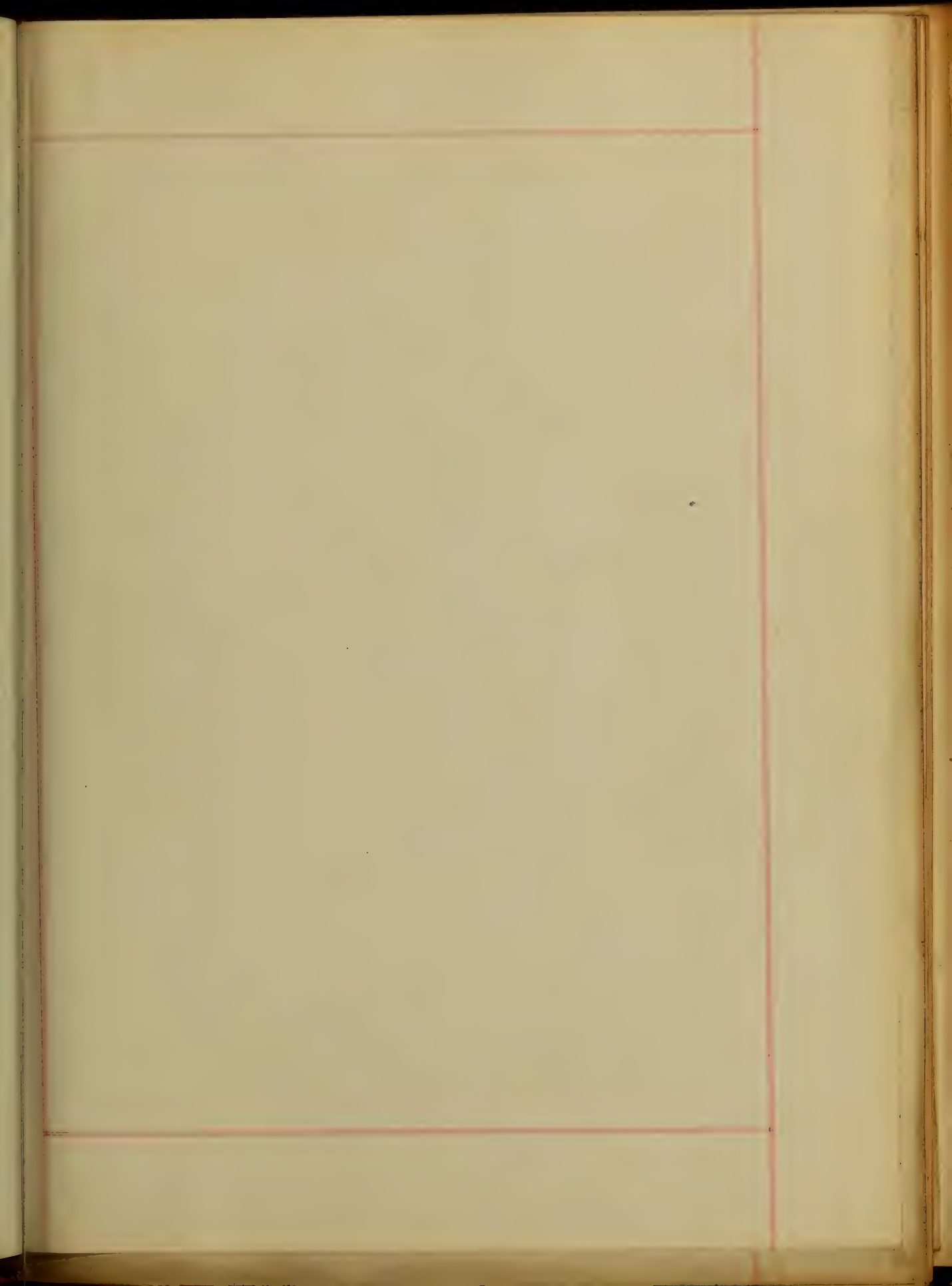


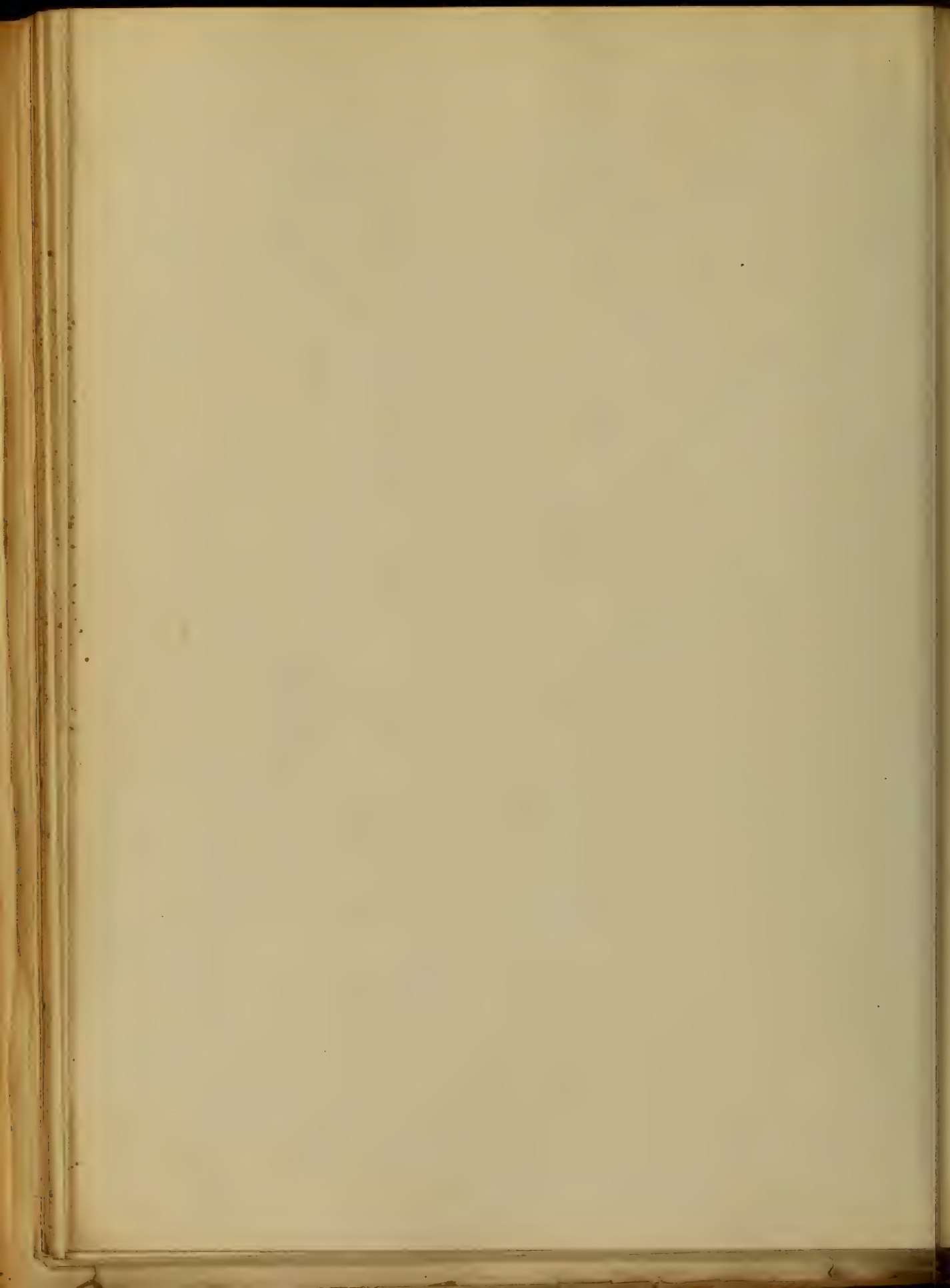


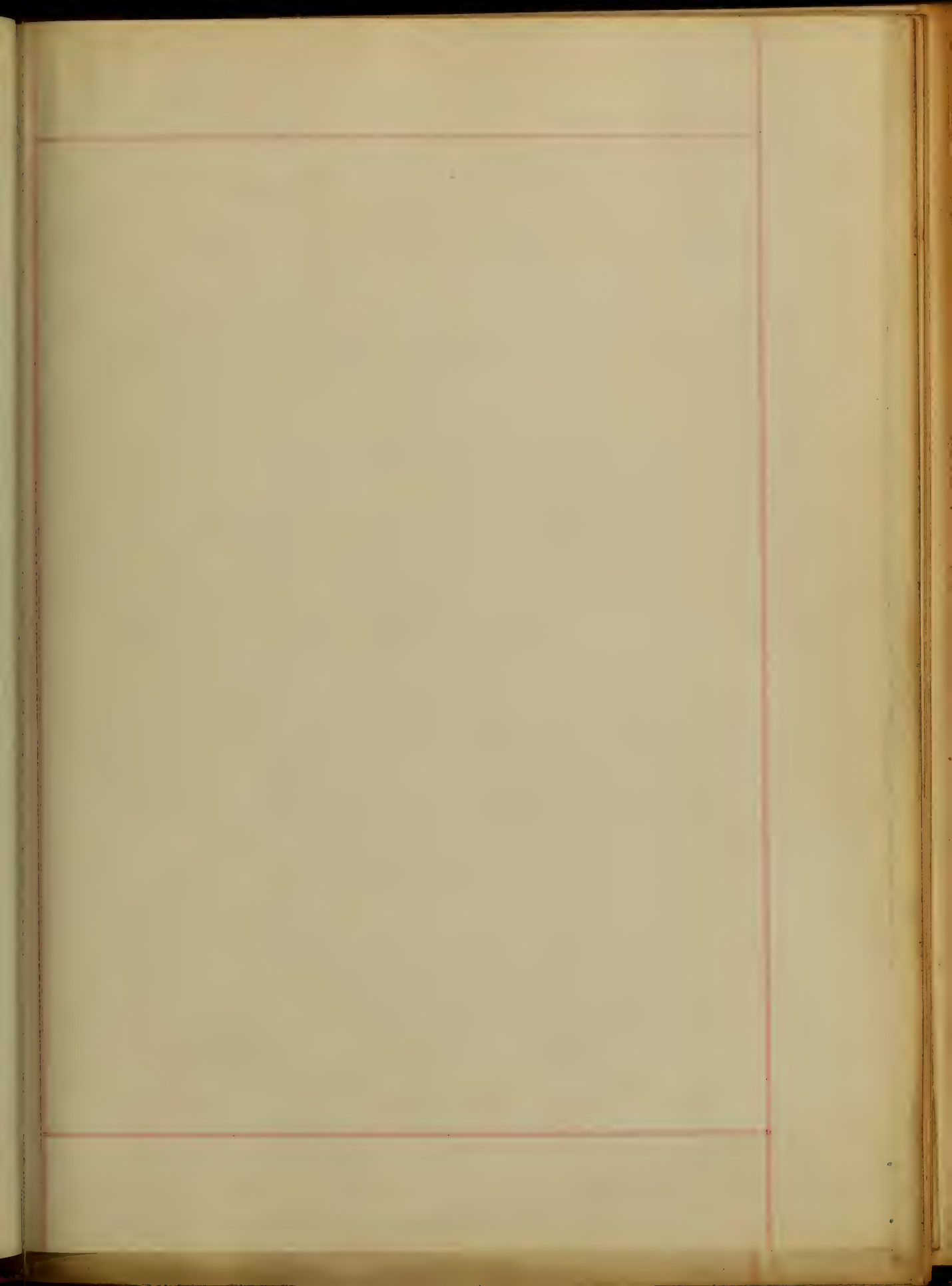


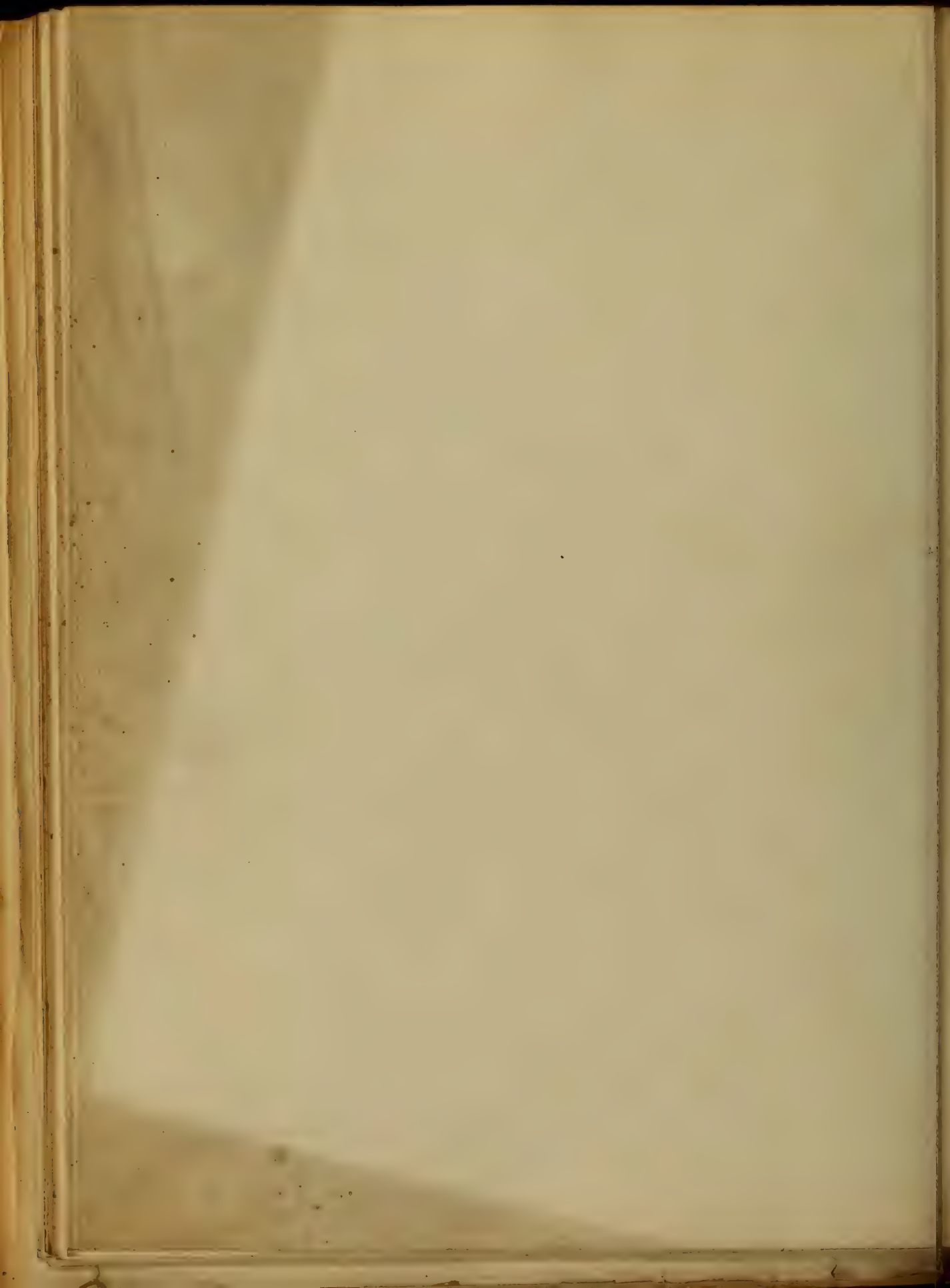










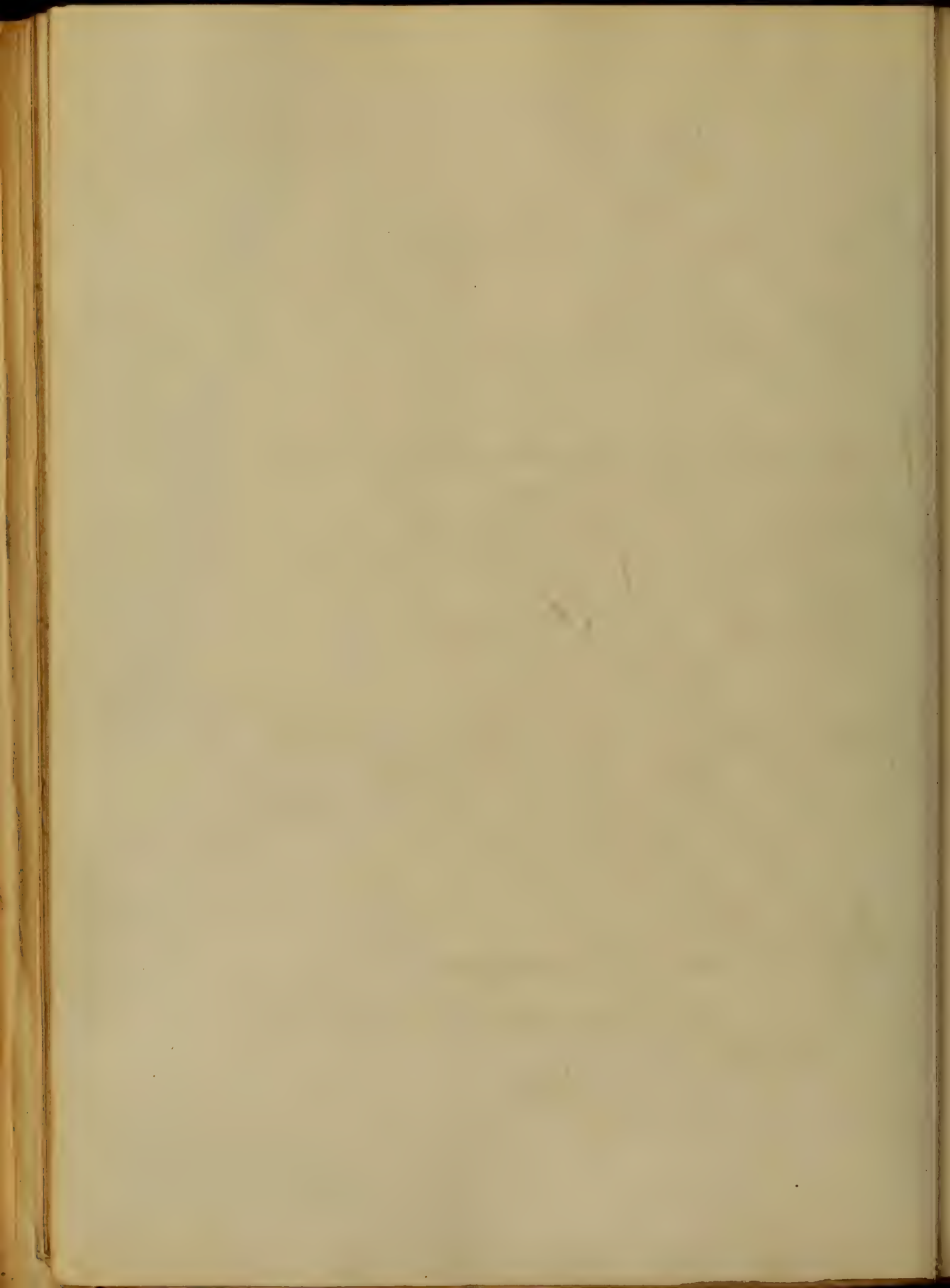


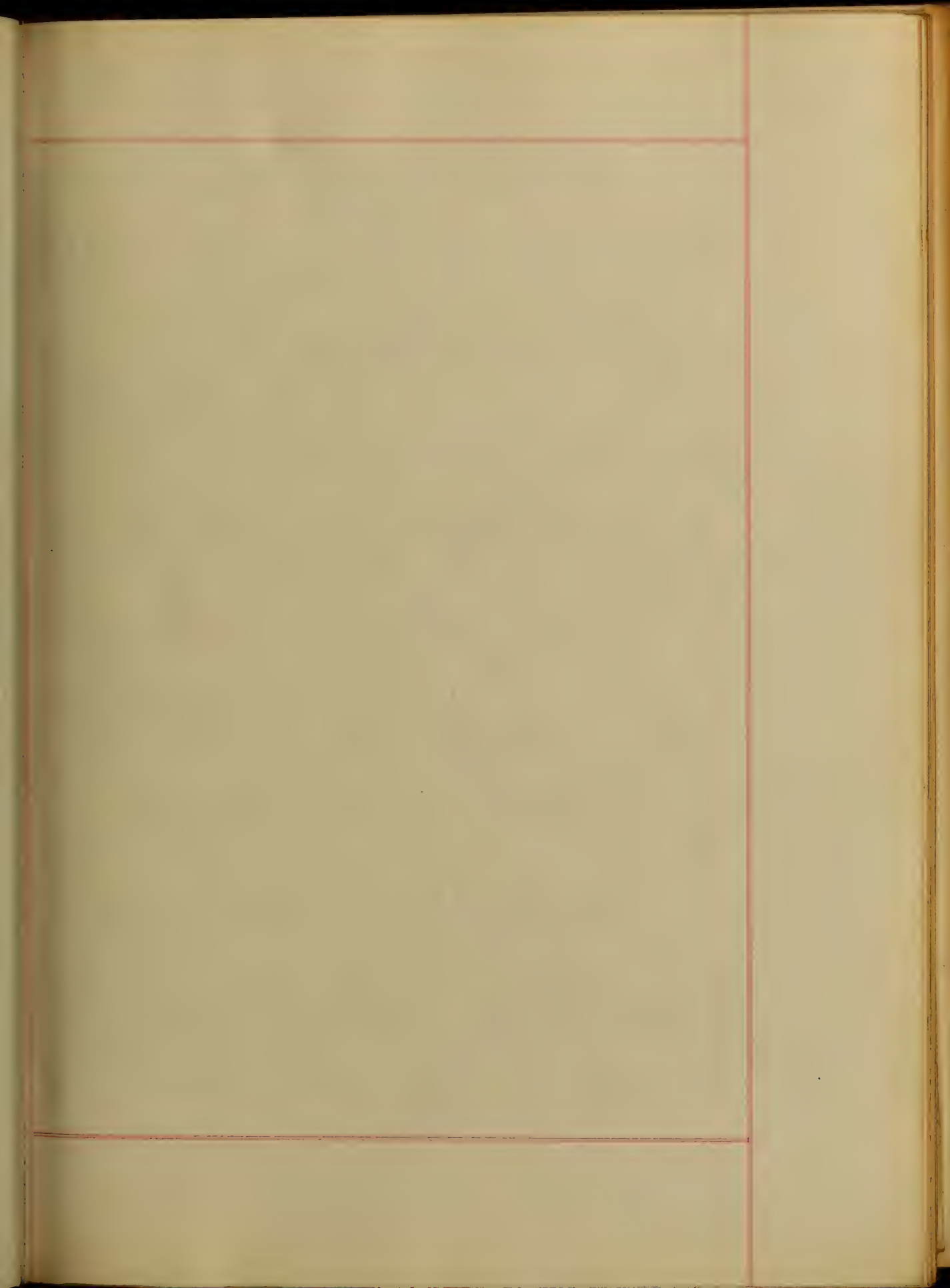
An
Inaugural Essay
on
Diphtheria

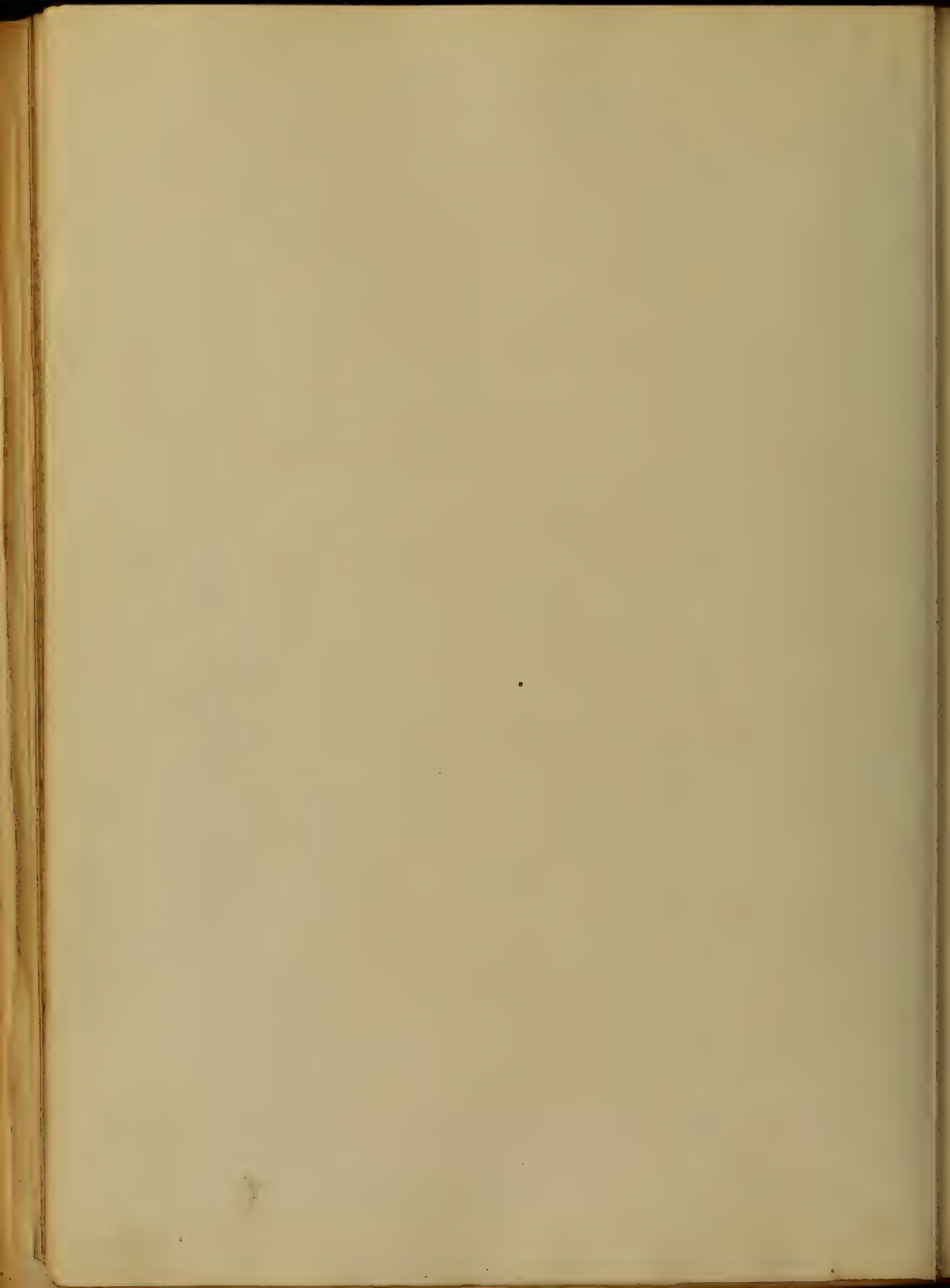
Respectfully submitted to
the examination of
The Provost, Regents and
Faculty of Physic

of the
University of Maryland,
For the Degree of Doctor
of Medicine

By
Jas. Thos. Sledge
of Warrenton N. C.
February
1877.





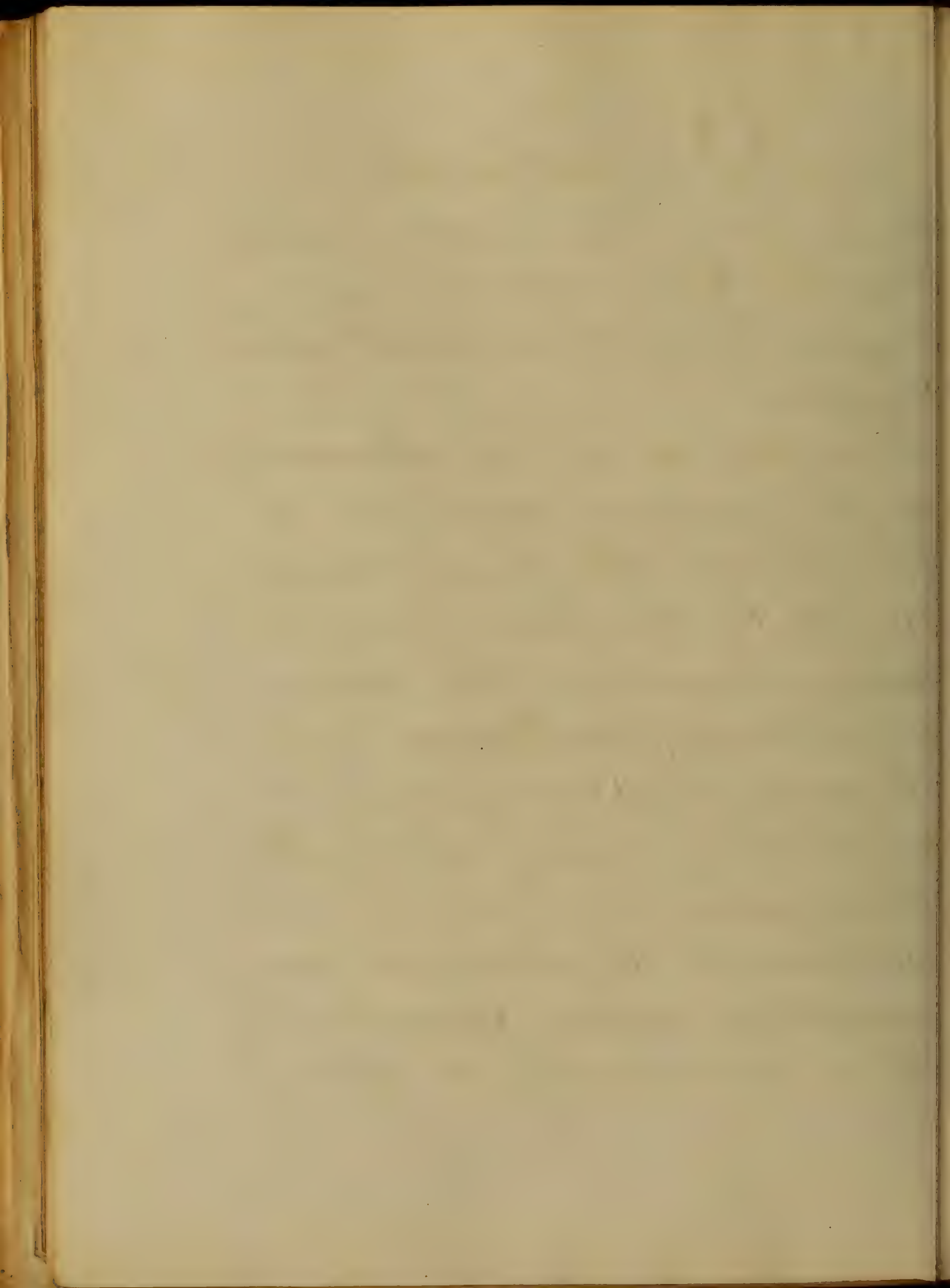


Diphtheria.

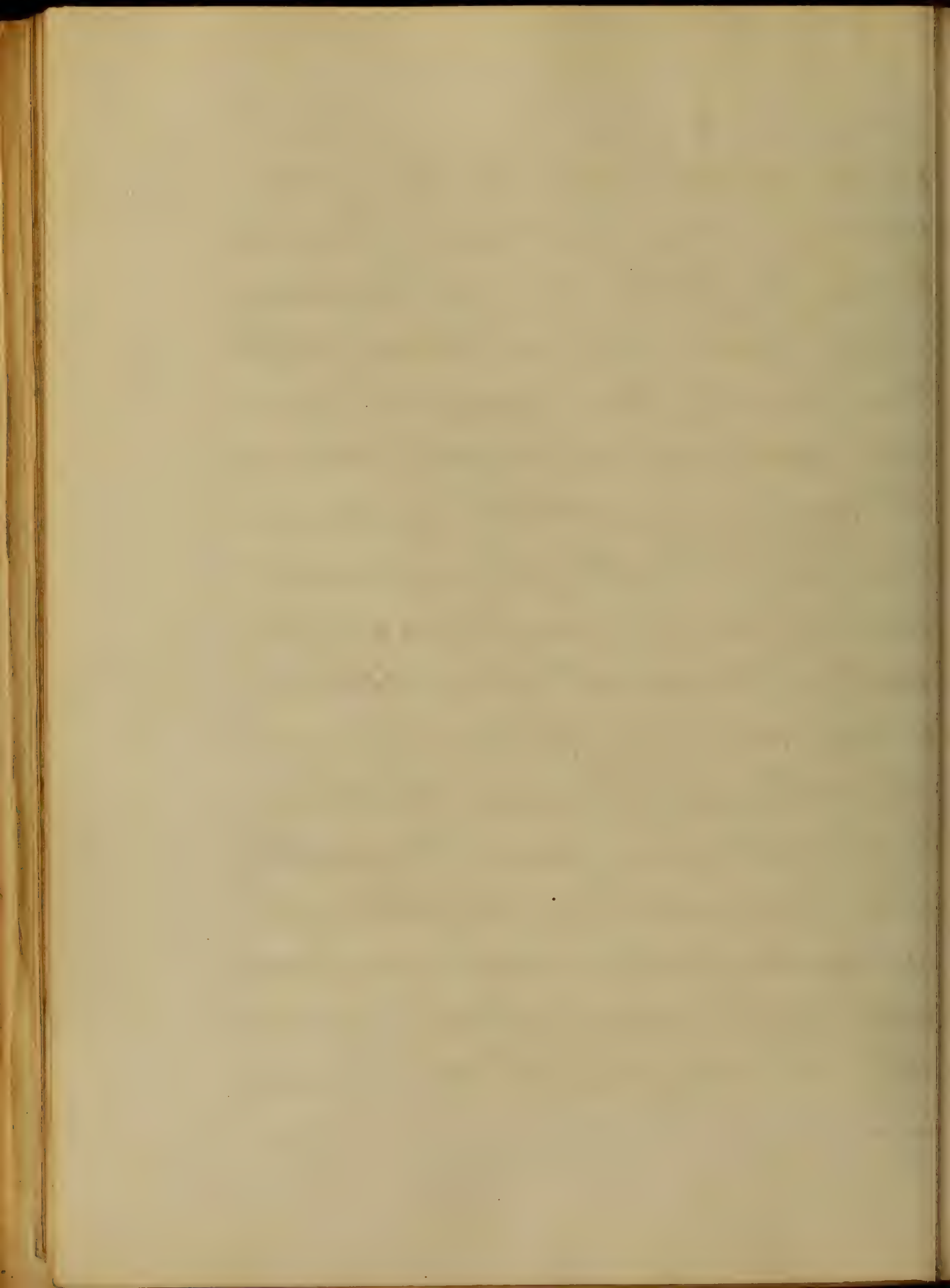
Synonyms. — Pseudo-membranous
Angina; Putrid Sore Throat;
Angina Diphtheritica; Diph-
theritis.

This disease is an inflammation
of the mucous membrane of
the throat and fauces charac-
terized by the formation of a
false-membrane. The name
diphtheria (from διφθερα, a skin
or membrane) was given to it
about forty years ago by M.
Bretonneau of Tours.

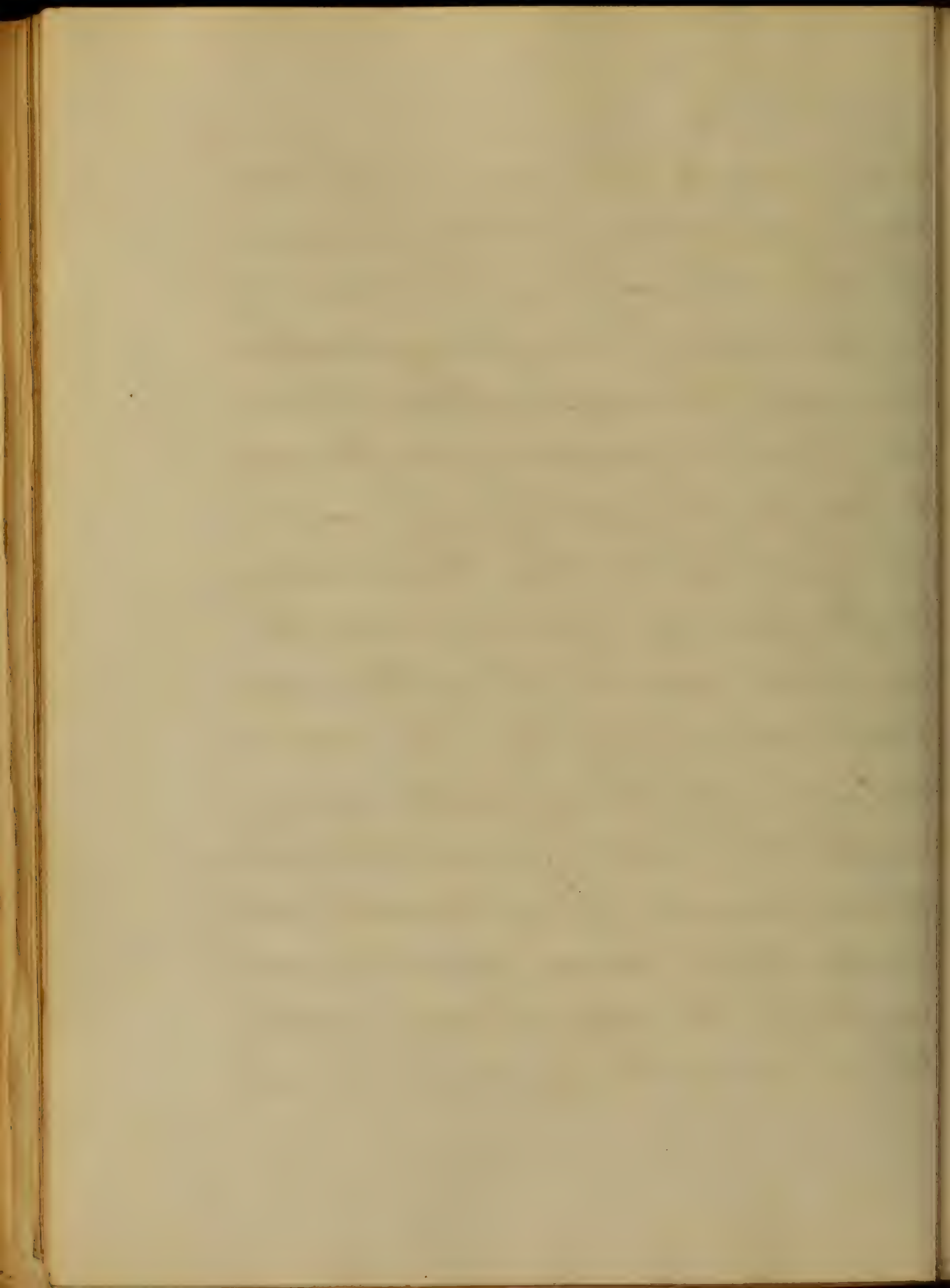
Although diphtheria may
sometimes occur sporadically,
it is eminently an epidem-



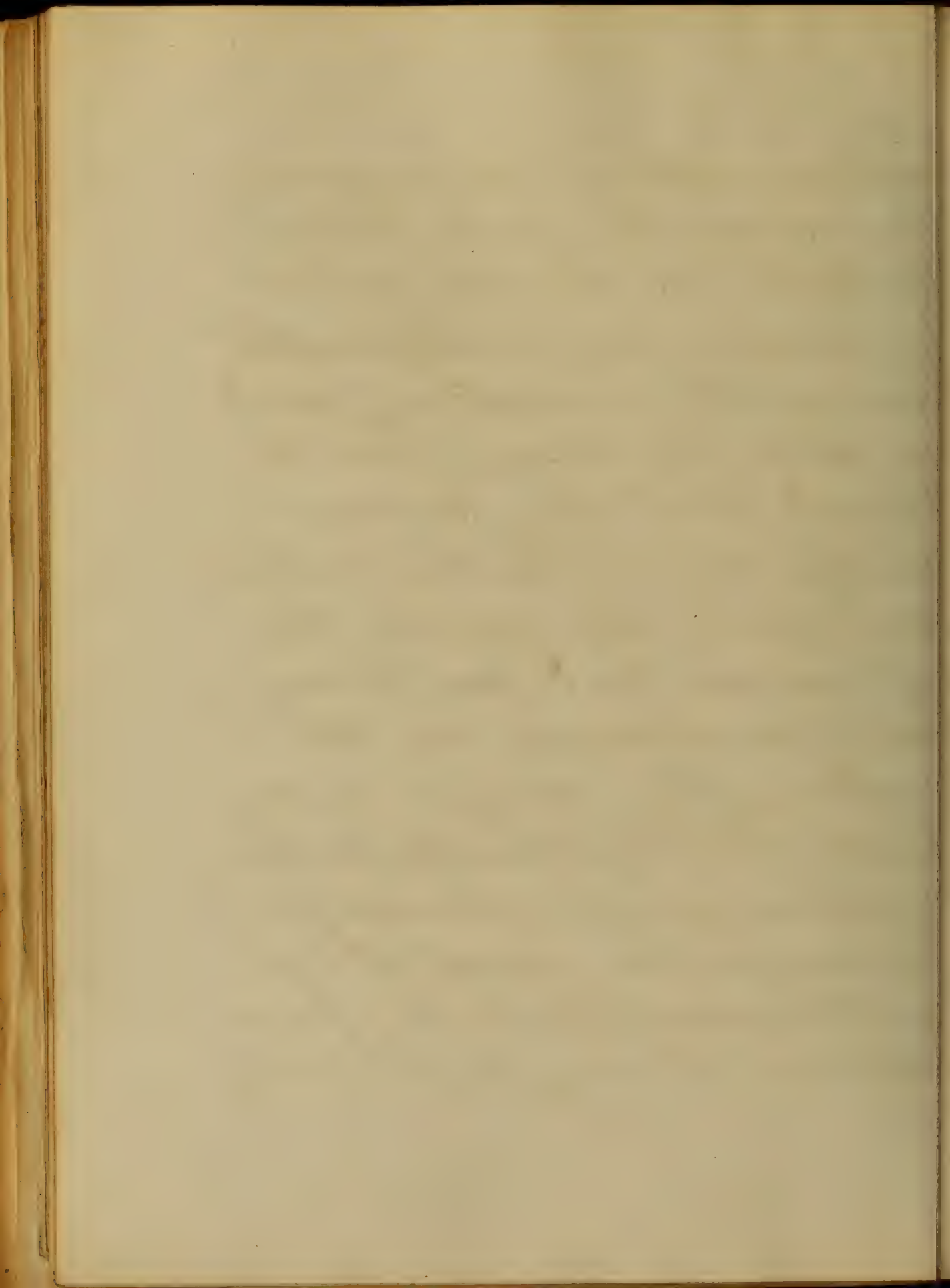
ic disease; up to the year
1858 it was not seen in New
York for fifty years, but since
that time, or at least within
the last ten years it has
not missed a single season.
It rarely ever attacks persons in
first-rate health, living under
good hygienic influences, but
rather those in whom there is
a low vitality of the tissues.
It attacks persons of all ages,
but children most frequently.
The true cause of diphtheria
is unknown, much confusion
and difference of opinion ex-
ists in regard to it. It seems



to be due to the presence of some
cryptogamic vegetable poison
in the atmosphere, which al-
lights upon the pharynx during
the act of inspiration, there
the low organism continues
to be propagated, and is ab-
sorbed into the blood, which
it poisons, giving rise to
the low grade of inflamma-
tion, resulting in the exu-
dation of the plastic mate-
rial which forms the false
membrane. But some con-
tend that since bacteria which
seem to be identical with
those found in diphtheritic

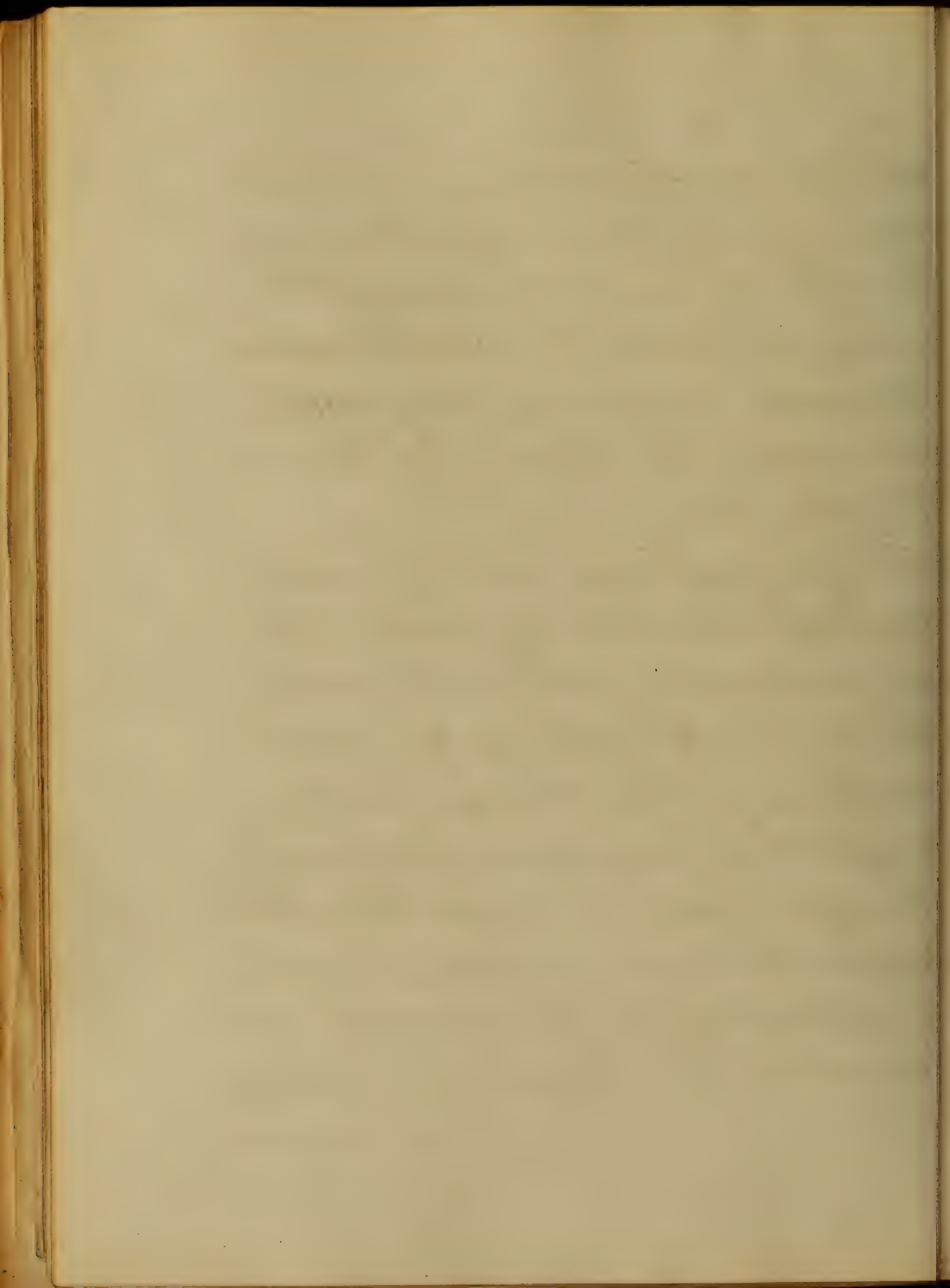


inflammations are frequently found on the gums between the teeth in health, without producing any irritation, that there exists a something which so alters the tissues and the blood, that they become a nidus in which the bacteria are early and quickly developed, so that from being few & innocuous in the system, they occur in myriads. The diphtheritic poison sometimes enters the system through the lungs. It is well known that this poison (whatever it may be) preferably

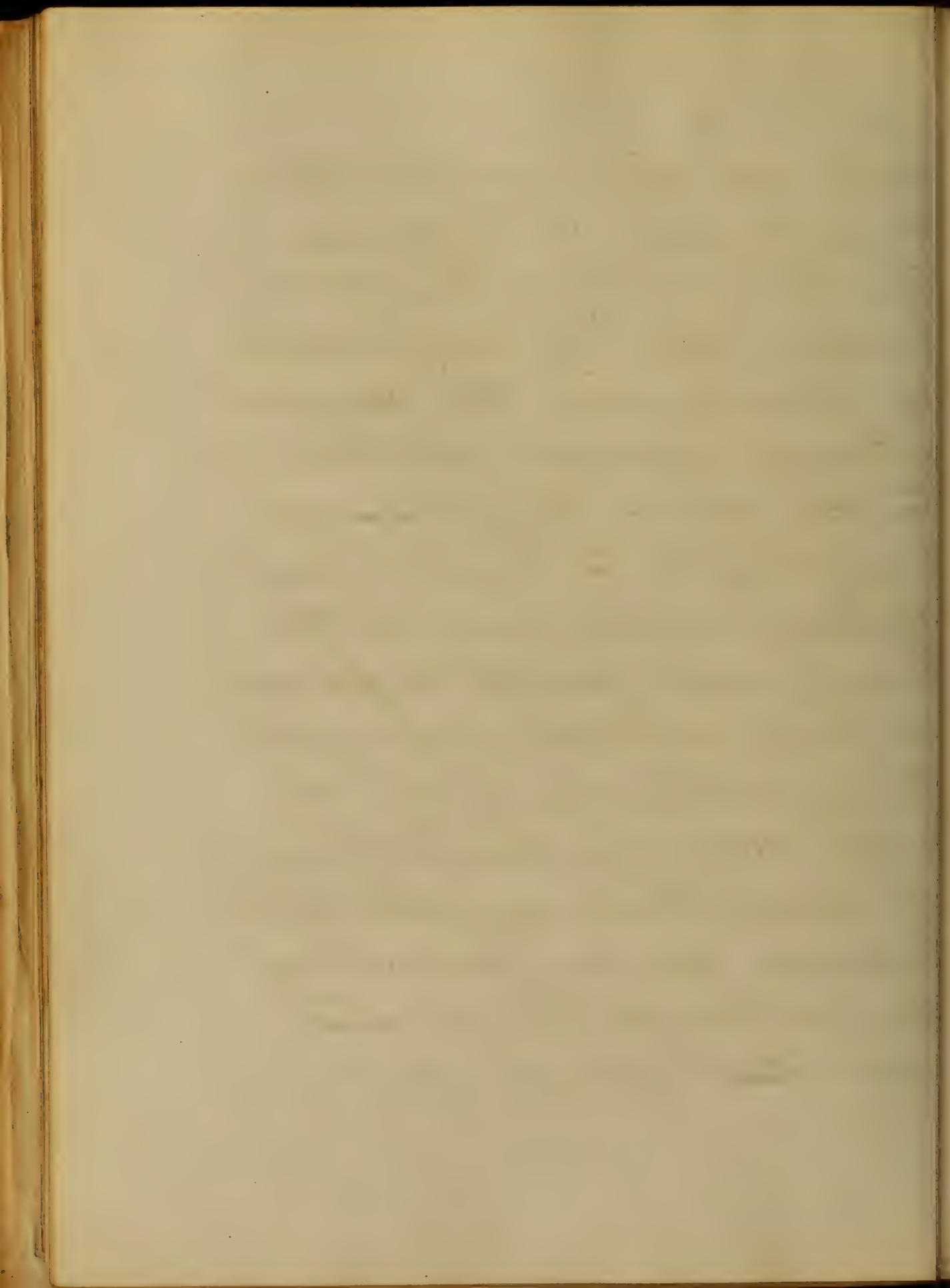


attacks such surfaces as are deprived of their epithelial or epidermic covering. It may attack the oesophagus, Stomach, vagina, conjunctiva, and even the lining of the external ear.

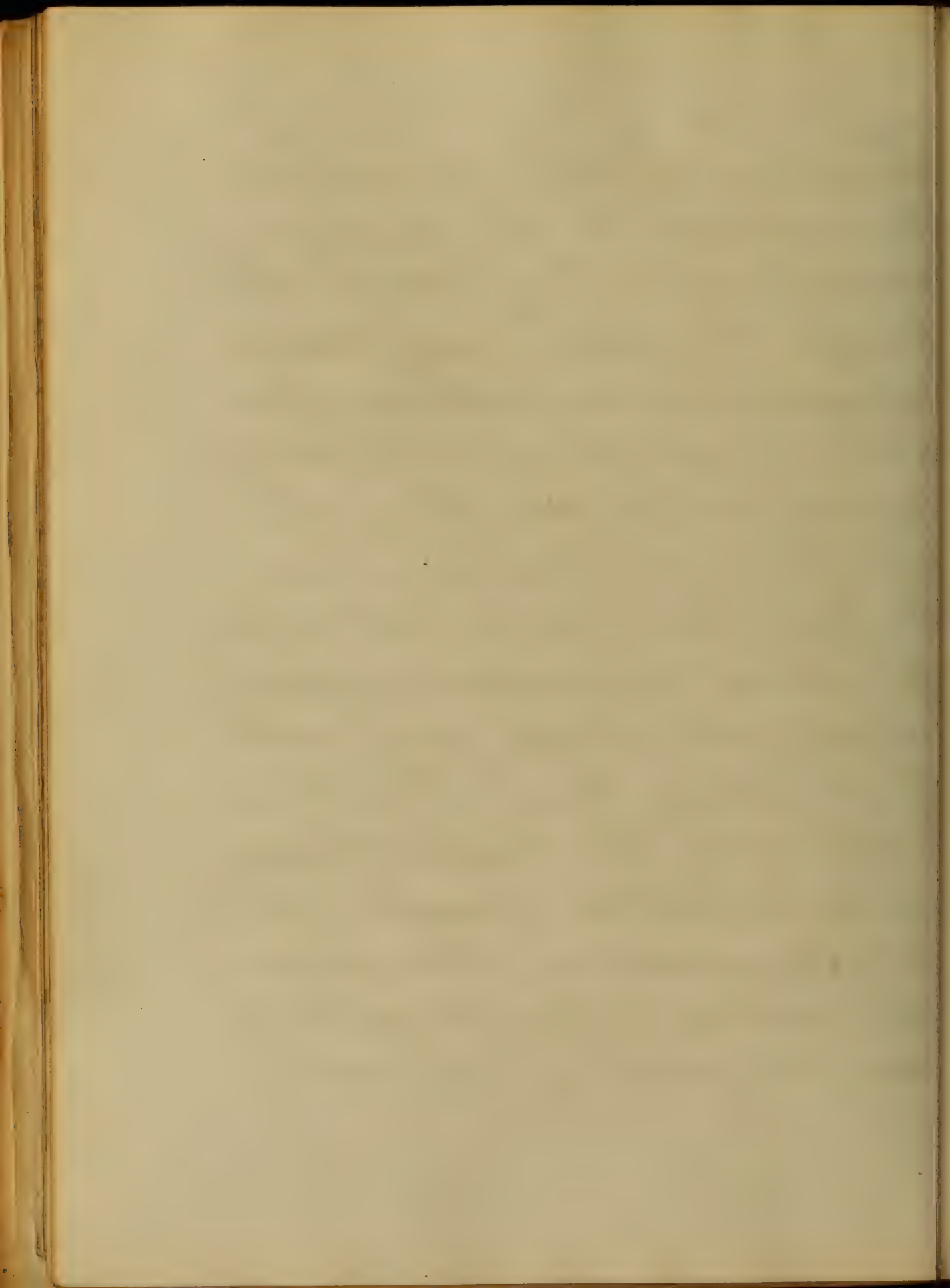
The symptoms are at first mild, resembling those of an ordinary sore-throat. There is a feeling of general malaise, chilliness with rigors lasting sometimes for hours, loss of appetite headache, tongue coated with a moist fur, the bowels are regular, the tonsils and fauces



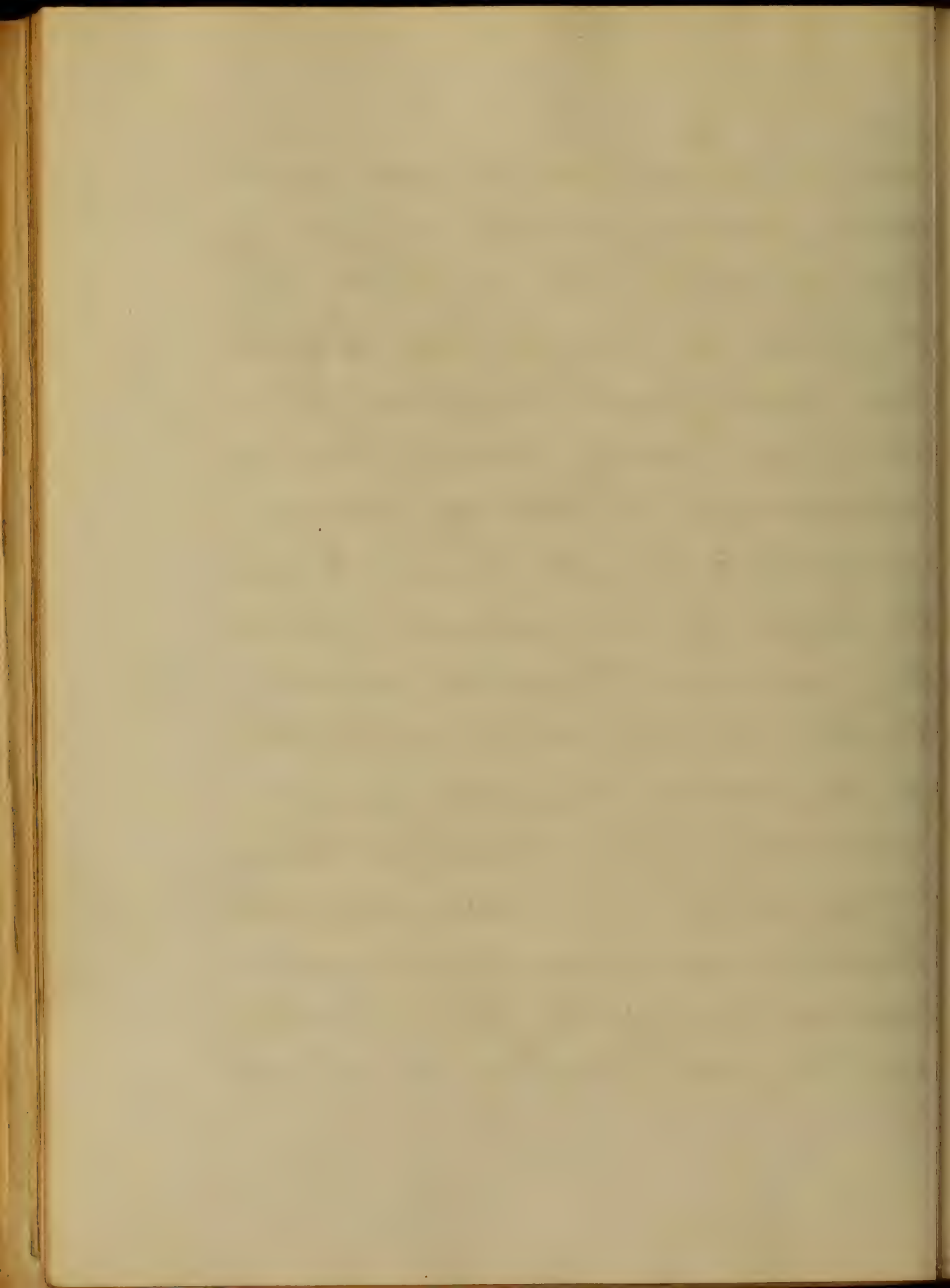
are red and swollen, there is a feeling of tenderness in the throat, but this soon passes off. The submaxillary glands and the cervical glands become swollen & tender. Soon the false-membrane begins to form, it first appears somewhere on the tonsils, soft-palate or pharynx, at first whitish or grayish, thin, particularly at its edges, occurring in patches, it soon thickens and often becomes darker, presenting the yellowish tinge and granular appearance of



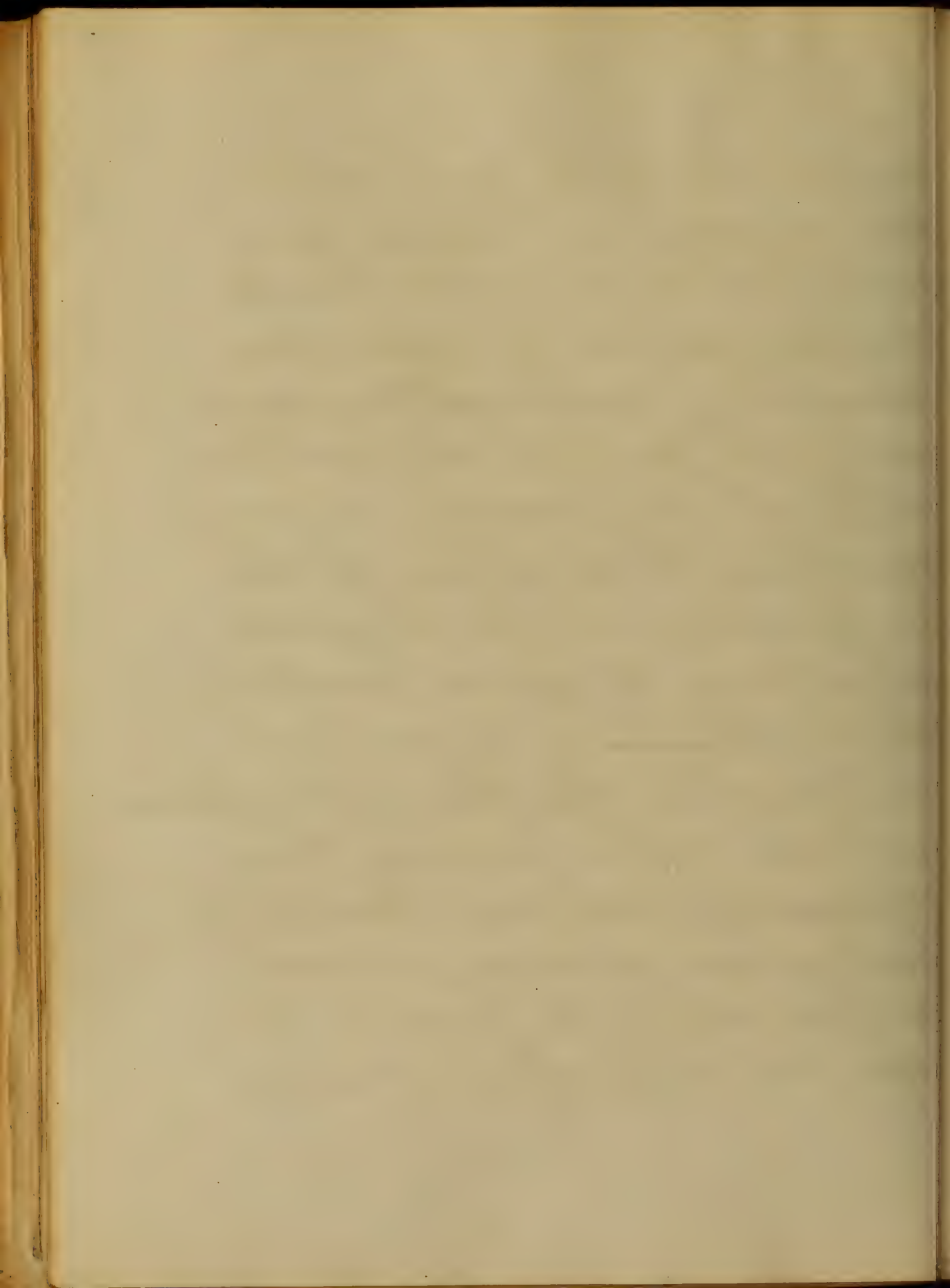
Chamois leather, is more or less adherent to the mucous membrane and if removed will bleed. The nares may become plugged and an ichorous flow come from them. The breath becomes fetid. Sometimes the symptoms at first are so slight that the patient will go about his usual employments, and it not infrequently happens that the true nature of the case is discovered too late to prevent a fatal termination. Then again the reverse takes place, there may be great febrile excite-



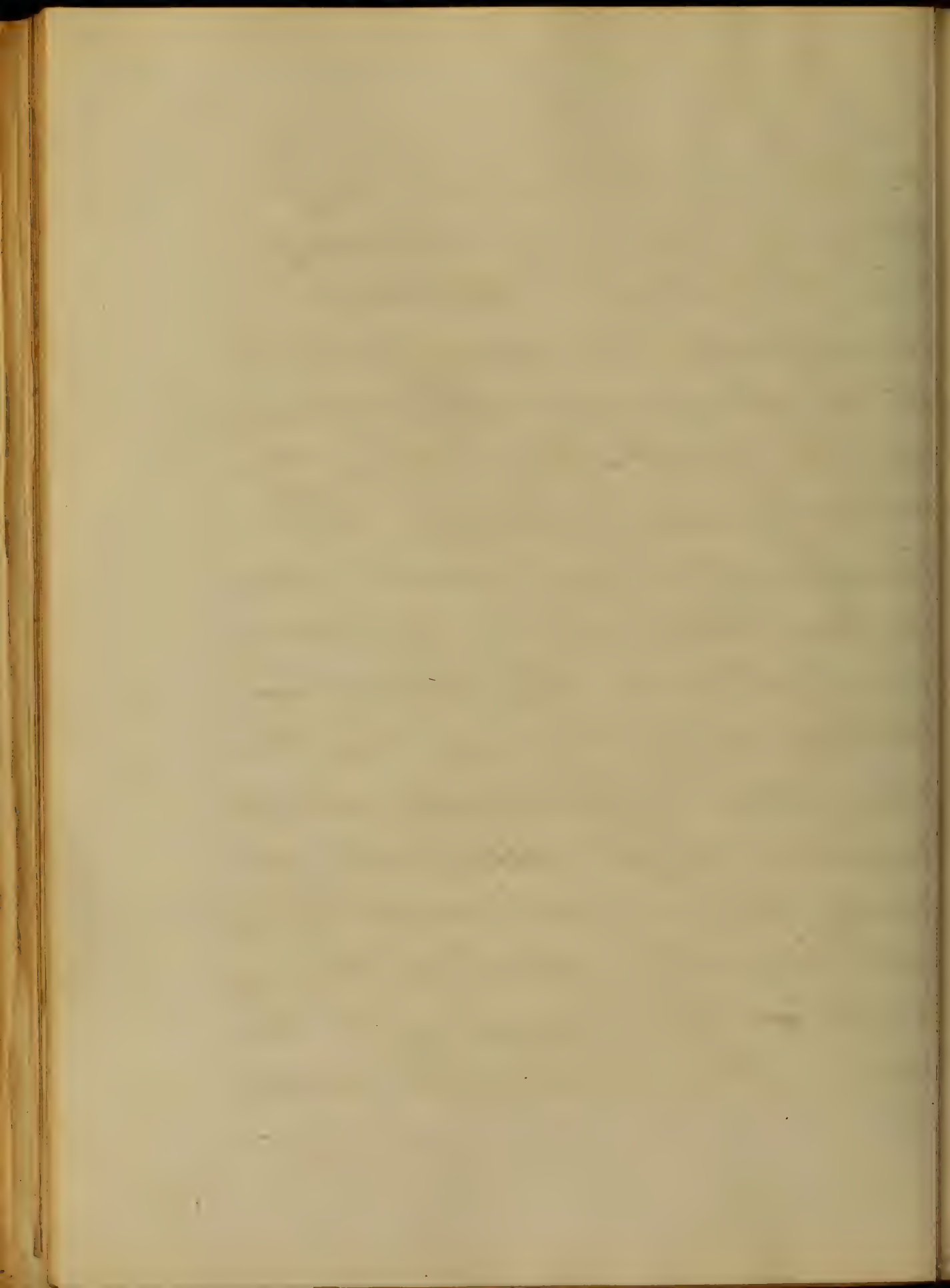
ment, pain in the ear head-
ache, aching of the limbs and
loss of strength, so that the
patient is compelled to take
his bed from the first. De-
lirium may occur, but is
unusual. Cases of severe
commencement have been
known to terminate favora-
bly in less than a week,
while on the other hand, those
of a mild commencement
generally end fatally, or take
weeks to effect a recovery. The
pulse varies in different
cases, it is often full and strong
in the first days of the disease



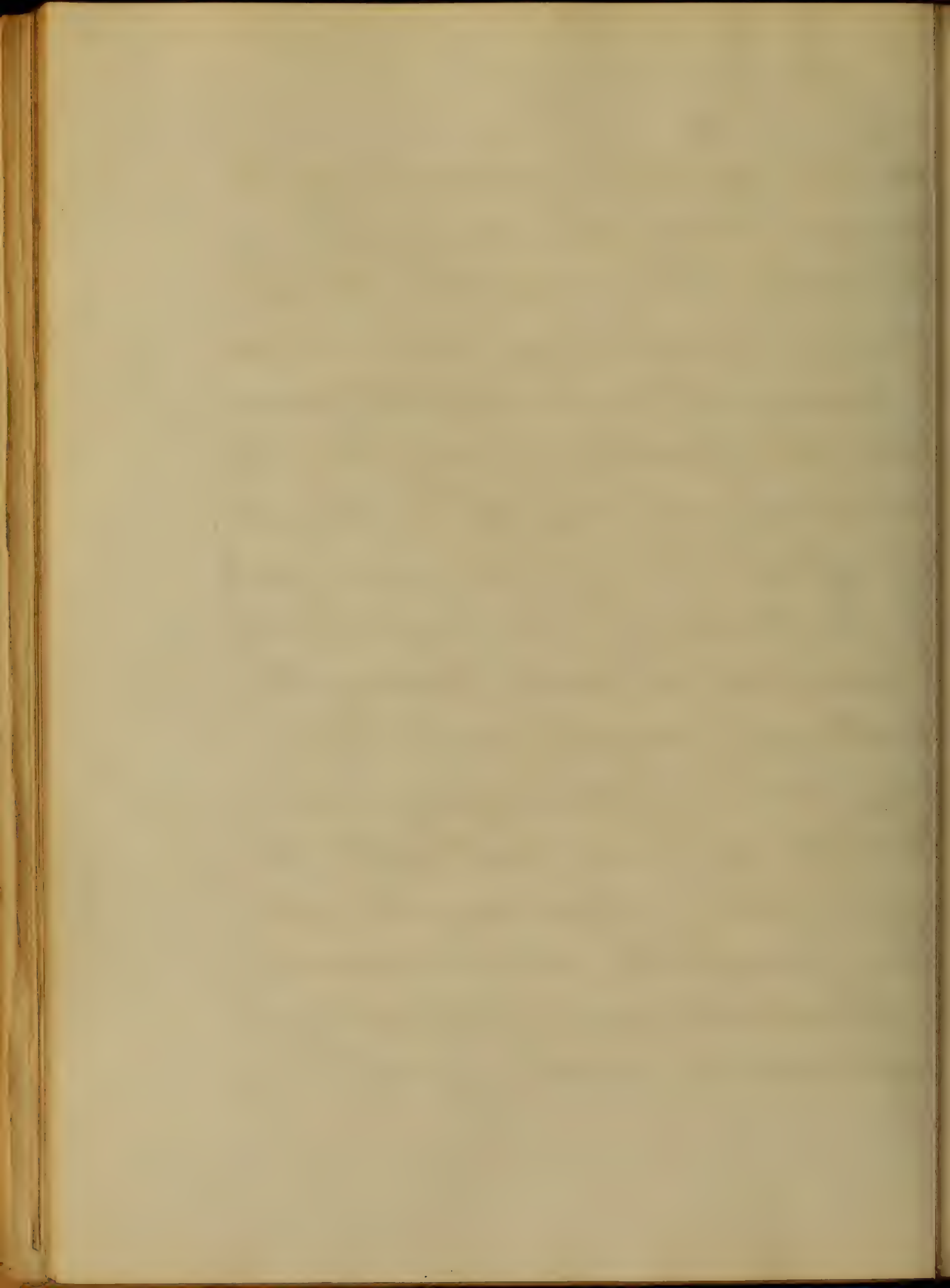
but in the latter part, when
the blood has become poi-
soned it is slow and weak,
In the course of a few days
snuffling respiration, cough
may be present or not, but
when it does occur, very much
resembles that of croup, The
inspiration is prolonged and
whistling, dyspnoea is extreme,
The countenance is anxious
and pallid and the little patient
in vain seeks for relief by a
change of position. Sometimes
there is an efflorescence on the
surface when the fever is high,
does not differ from ordinary



erythema so common in fe-
brile affections of infancy
and childhood, and soon
disappears, in many patients
it is absent, generally occurring
in the first stages when the
circulation is active. The
temperature in most cases
is less than it is in Scarlet-
fever, and in the advanced
stages may become less than
normal. Albumen in the
urine, often occurs at an
early period, but sometimes
not before the close of the first
week or the beginning of the
second, this is one of the evidences



of the systemic poisoning, the
general cachectic condition of
the patient is another. Diph-
theria is infectious, but is rare-
ly transmitted, it is well known
that the sputum of diphtheritic
patients and bits of the pseudo-
membrane may communicate
it, for doctors have been known
to contract it from having the
material coughed into their
faces while cauterizing the
throats of their patients, or
voluntarily drawing it into
their mouths while rescuing
a tracheotomized patient from
asphyxia, by sucking out thro.

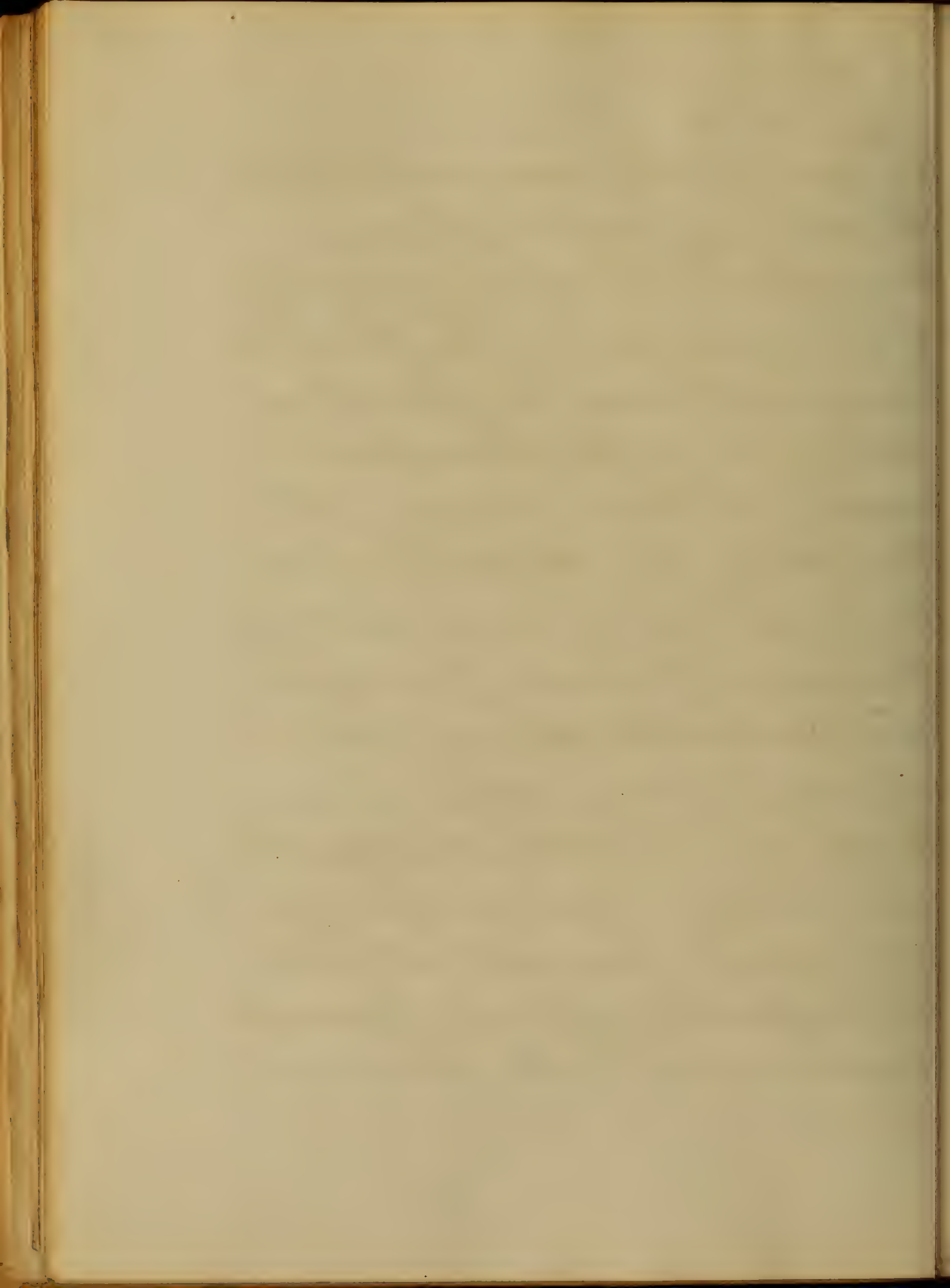


the wound, the accumulations
threatening suffocation,

Sequelae: Paralysis generally
of the muscles of the pharynx
though, it may be general, is
one of the most prominent
sequels of this disease, then
there may be defective vision.

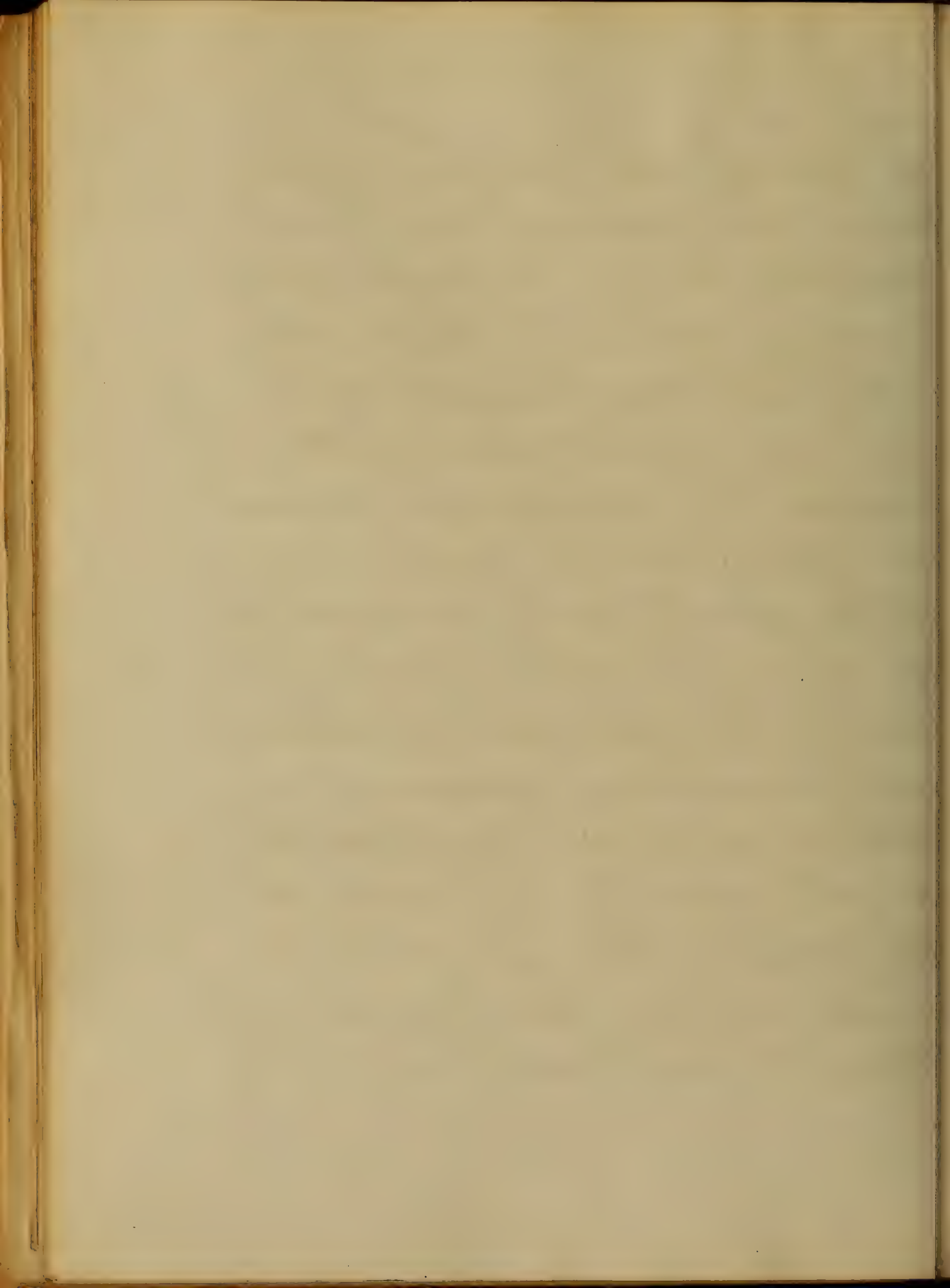
The patient is in a state of
splanchnemia, presents a pale
and cachectic appearance,
which is very noticeable —

Prognosis is rather unfavorable
when there is intense pharyn-
gitis, great cervical cellulitis
and adenitis, extensive pseudo-
membrane, with the phenomena

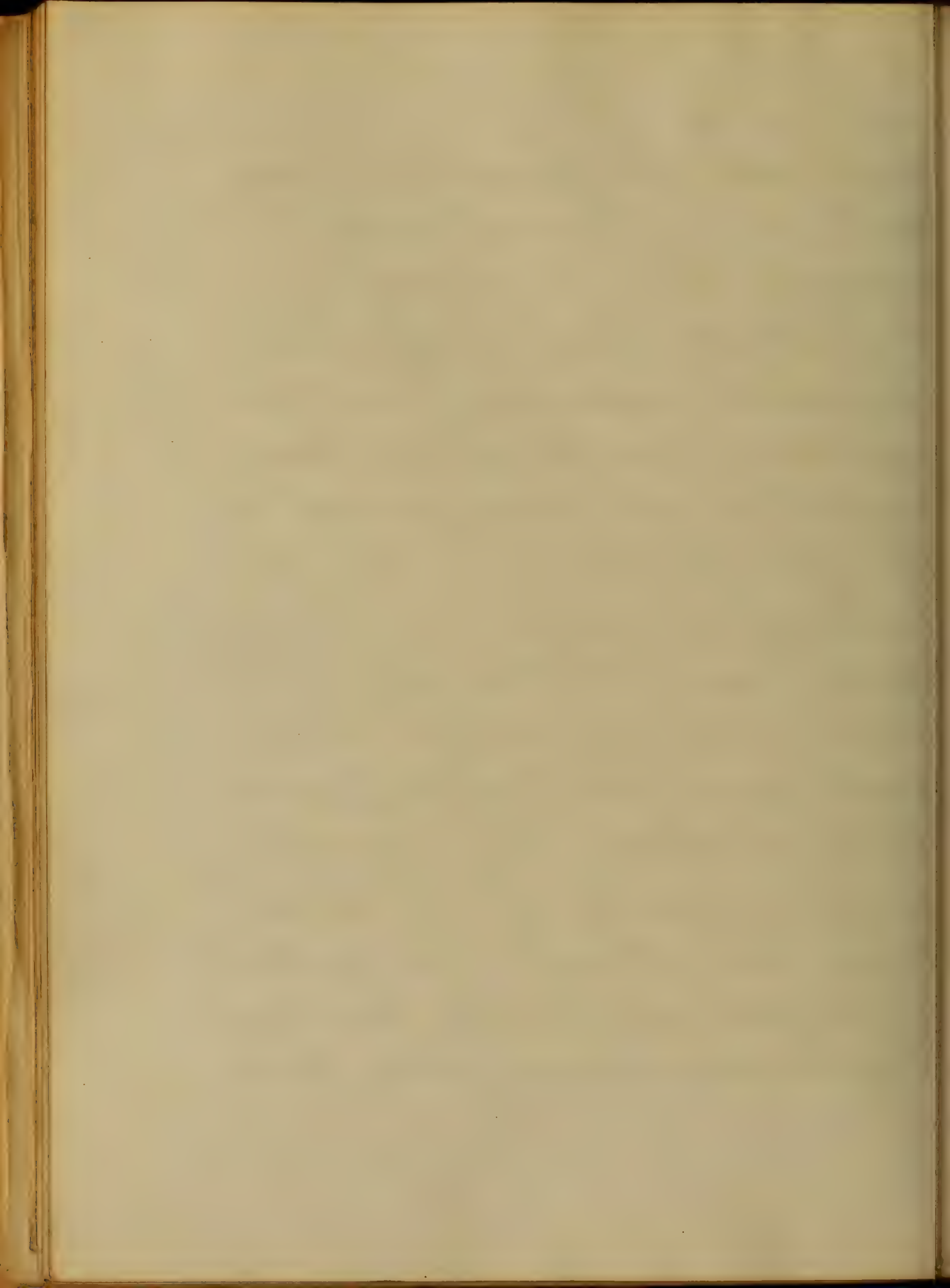


of croup, the croupy cough, voice and respiration, Great acceleration of the pulse continuing after the first week, a pallid countenance, with softness or flabbiness of the tissues, the occurrence of haemorrhage from the fauces or other parts, are prognostic of an unfavorable ending.

But if the inflammation, mucous and glandular, remain of a mild grade, if the strength is not greatly impaired and the constitution is good, and there are no laryngeal symptoms, a good result is highly

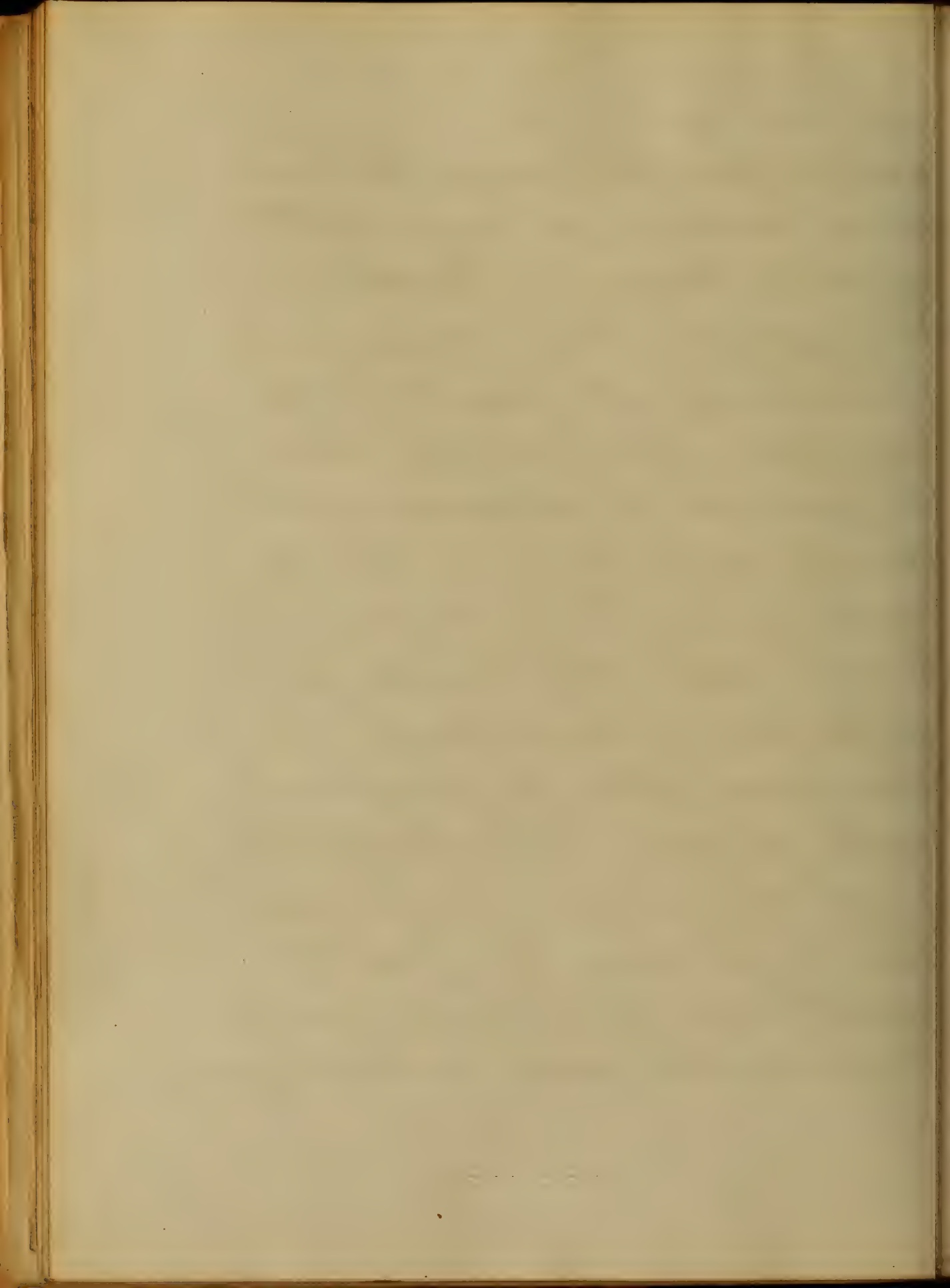


probable. The paralysis may continue for several weeks or months before recovery. Probably the larger proportion of deaths occurring from this malady have been due to suffocation in consequence of the obstruction in the air passages caused by the false membrane. The severity of the disease as a general thing lasts from five to fifteen days. Patients under three years seldom recover. If the secretions are stopped the patient will die in twenty-four hours. Dyspnoea and irregular pulse.



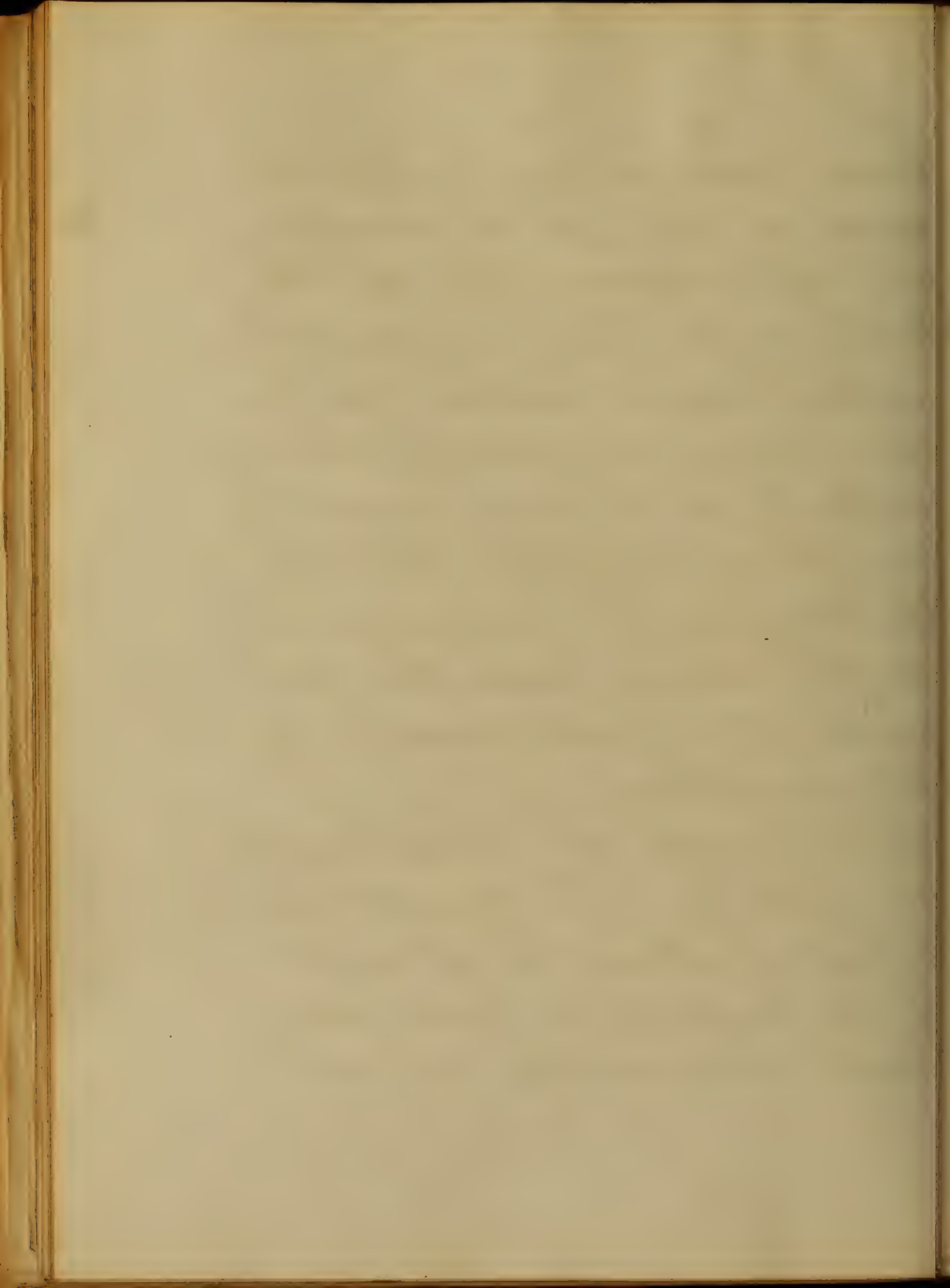
are unfavorable signs, Patient is in danger as long as the glands remain swollen.

Diagnosis. This disease is sometimes difficult to distinguish from croup, here the presence of albumen in the urine will aid in the diagnosis as this is rare in croup, also diphtheria is epidemic, while croup is sporadic, May be complicated with measles, thrush, Scarlet fever, and sometimes from its low type may at first be mistaken for typhoid fever, Diphtheria may be distinguished

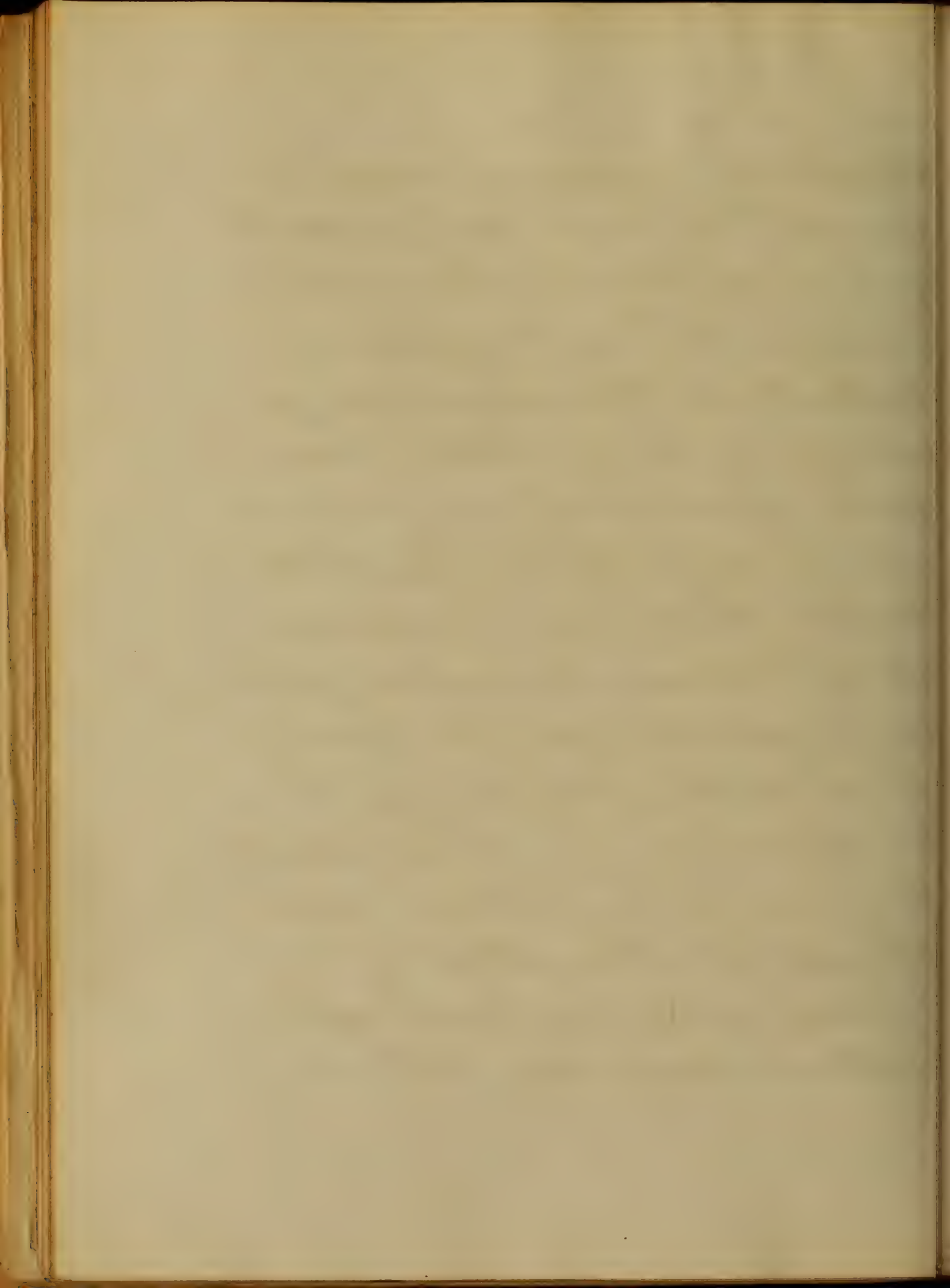


from scarlatina by the absence in the first, of vomiting and efflorescence, and in the latter of the fibrinous exudation on the fauces, unless diphtheria occurs as a complication with it, as it very frequently does. From typhoid fever by the absence of tenderness in right iliac fossa, the rose-spots &c. & from measles by the eruption

Treatment. The treatment should be both general and local. Sustain the strength of the patient by good food, tonics, Stimulants &c. all



depletory measures must be avoided. If constipation exists give a mild laxative as Hew-lands or Hurry's Magnesia, Chlorate of Potassium gr v or vi every 2 or three hours has a good effect, Quinine & Iron are indispensable, Carbolic Acid, Sulphur, Permanganate of Potassium is also good as a gargle - gr ij to Aqua zj . If exudation blocks up the air passage an emetic should be given if the patient can stand it, Alum Pulv zj or Ipecac gr x . For local application may use Nitrate of



silver R Argenti Nitrat gr. X-XX
Aqua ʒi

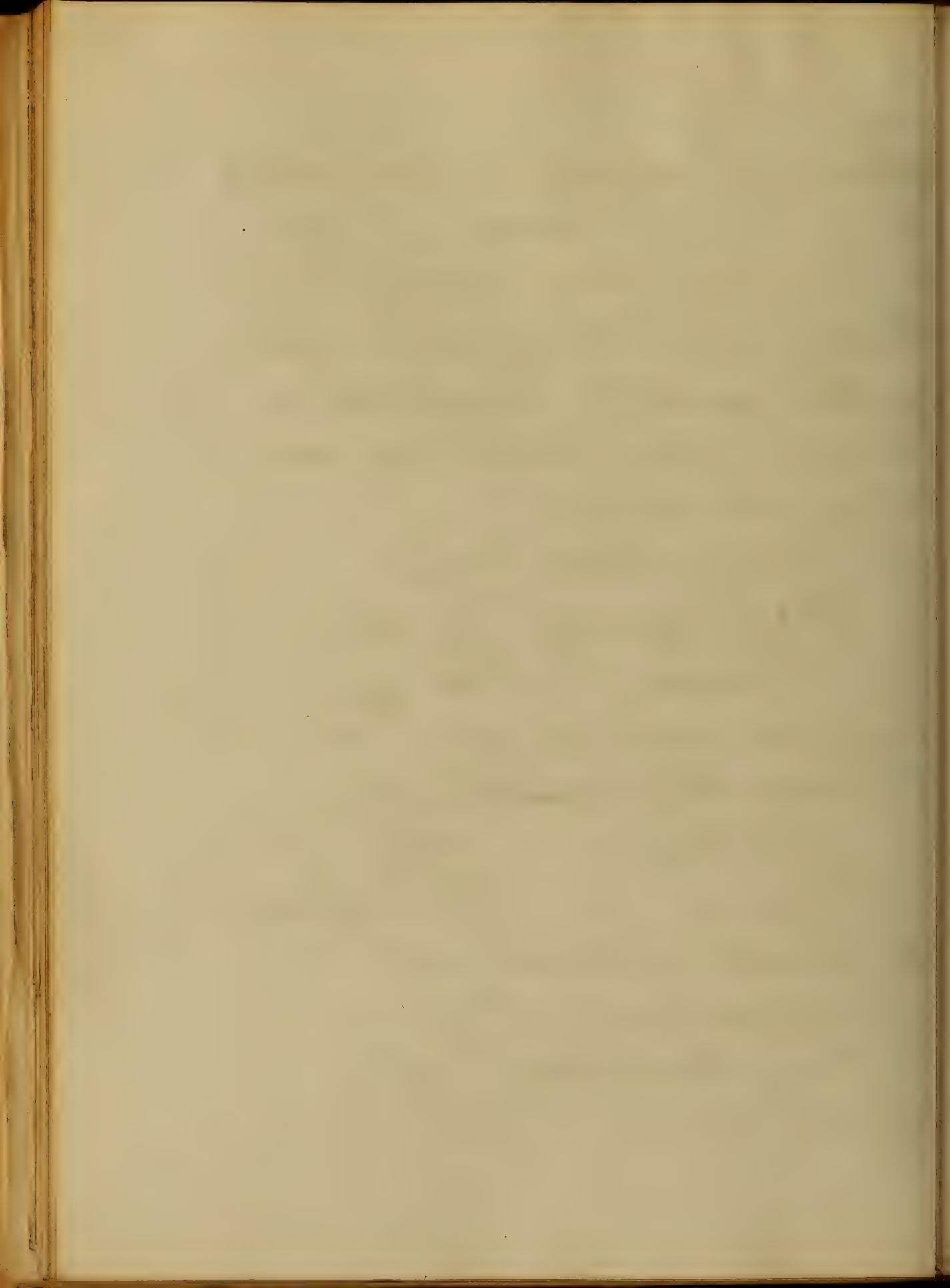
or in more severe cases in
stick-form to be applied light-
ly and quickly, from 3 to 6
times a day, with an as-
tringent gargle

R Potas. Chlorat. ʒij
Acid Pyrolig. ʒij-iv
Aqua Oss ʒss

Sig. Use as a gargle ^{no} or

R Sodae Hyposulph ʒij
Glycerine ʒij
Aqua ʒvj - Gargle

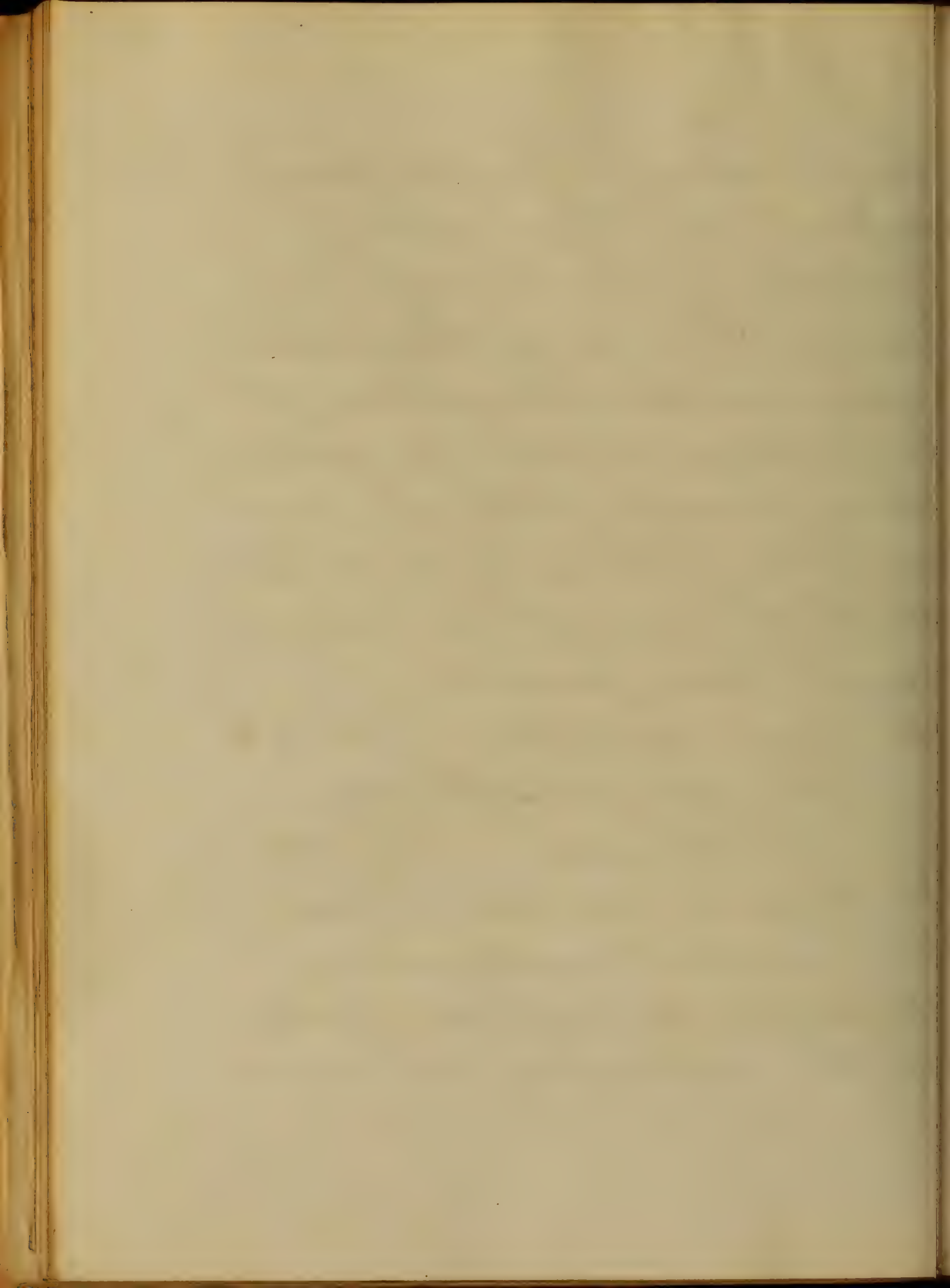
or Acid Carbolic gr v
Glycerine ʒij
Liq. Ferri Subsul. ʒij
Sig apply with a brush - ^{no}



The following is the treatment employed in the Catholic Foundling Asylum of New York: As soon as the patient comes under observation the following mixture is applied every second or third hour over the fauces by one or two applications with a large camel hair pencil:

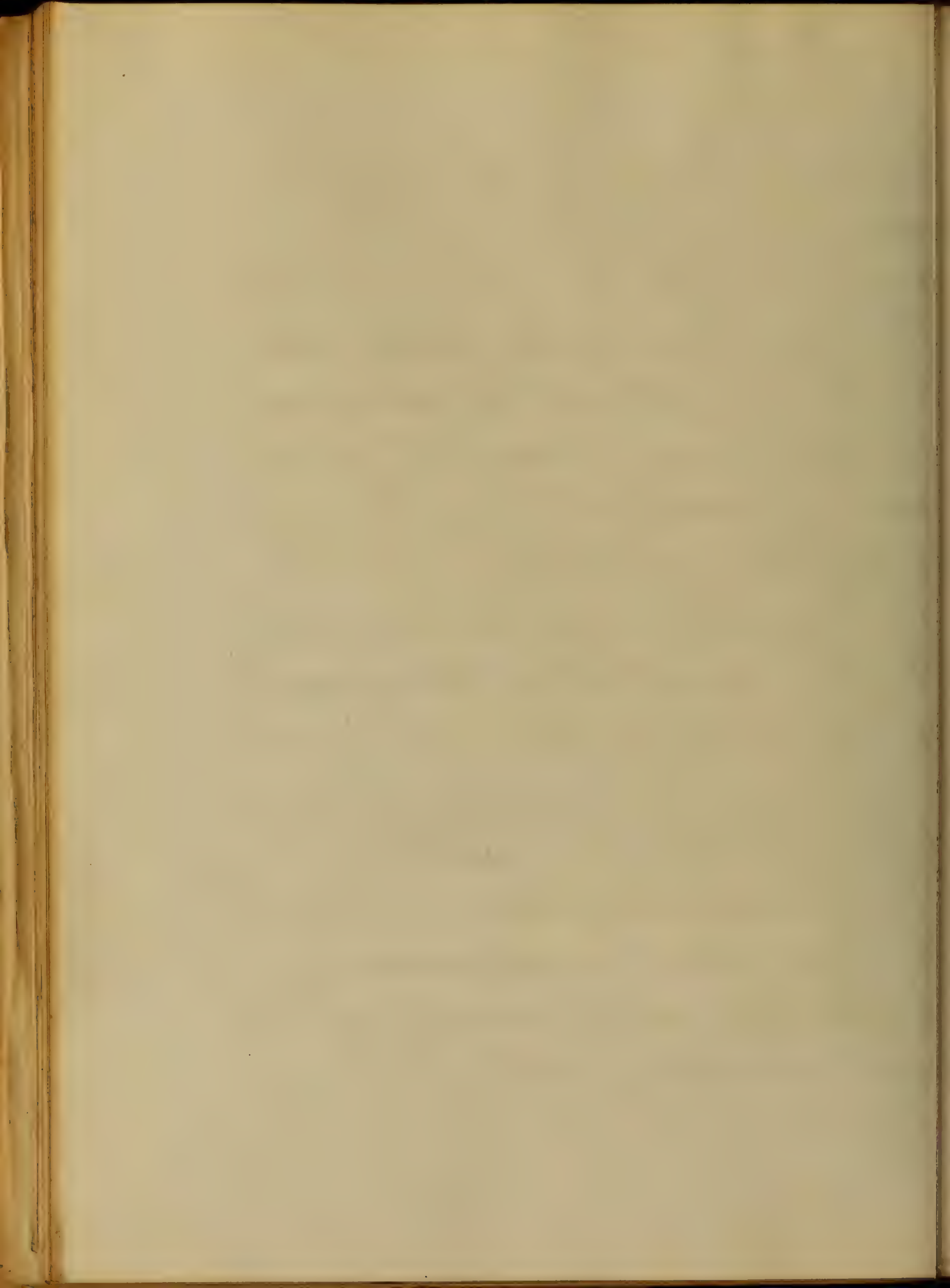
R Acid carbolic $\text{gtt } \text{v} \text{ to } \text{x}$.
Liq. ferri subsulph. ʒij .
Glycerinae ʒij . ℥ss .

If there is discharge from the nostrils indicating diphtheritic inflammation of the Schneiderian mem-



20
brans a little of the same
mixture diluted with an
equal amt of warm water
is injected into each nos-
tril every three to six hours,
by means of a small glass,
ear or nostril syringe, with
a knob or button at the
end of the nozzle. One-third
to one-half of a teaspoonful
of the diluted fluid is a
sufficient quantity to em-
ploy for each nostril.

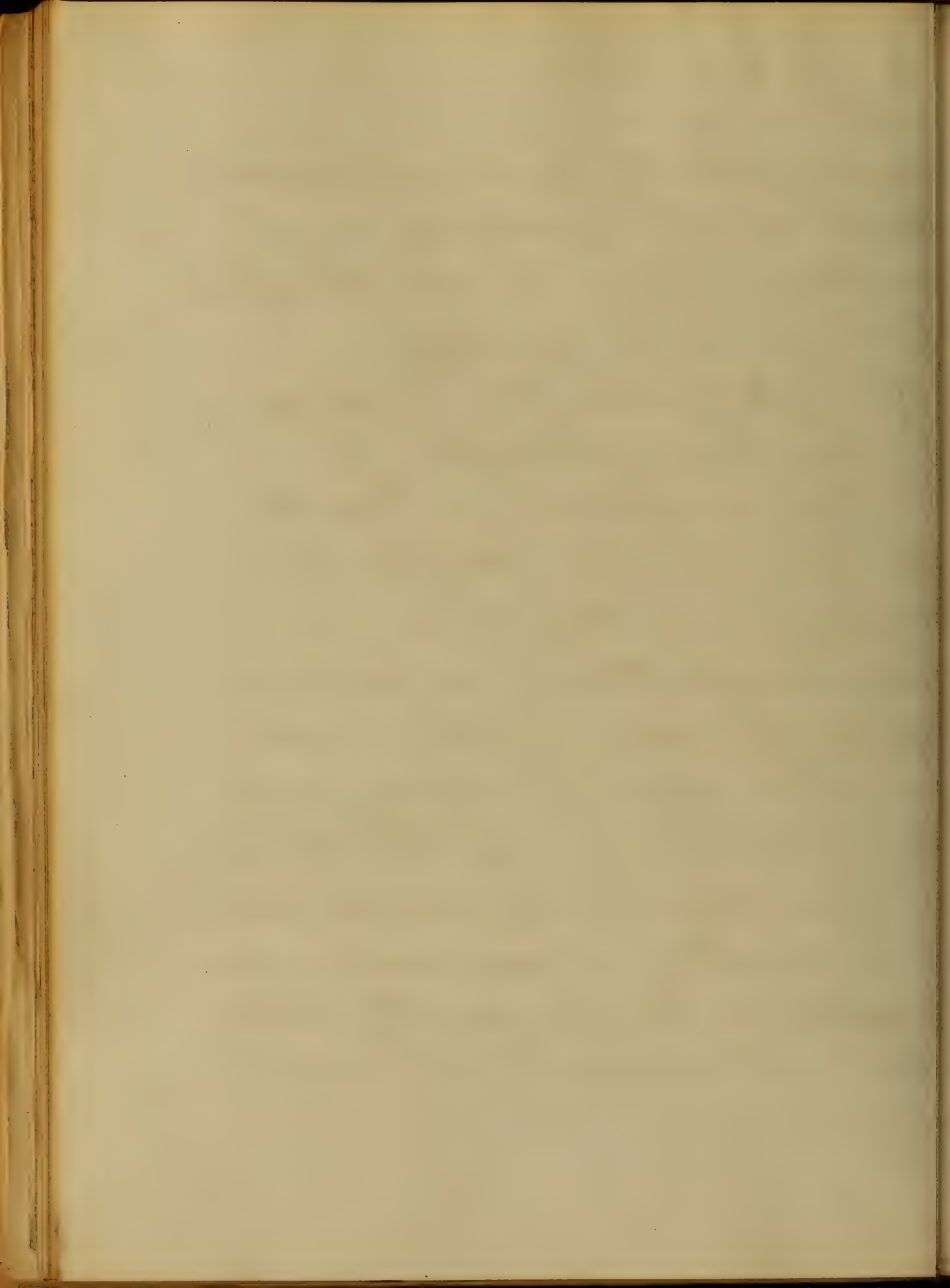
Quinine, in doses of one
to two grains, according
to the age and severity of the
case, is administered about



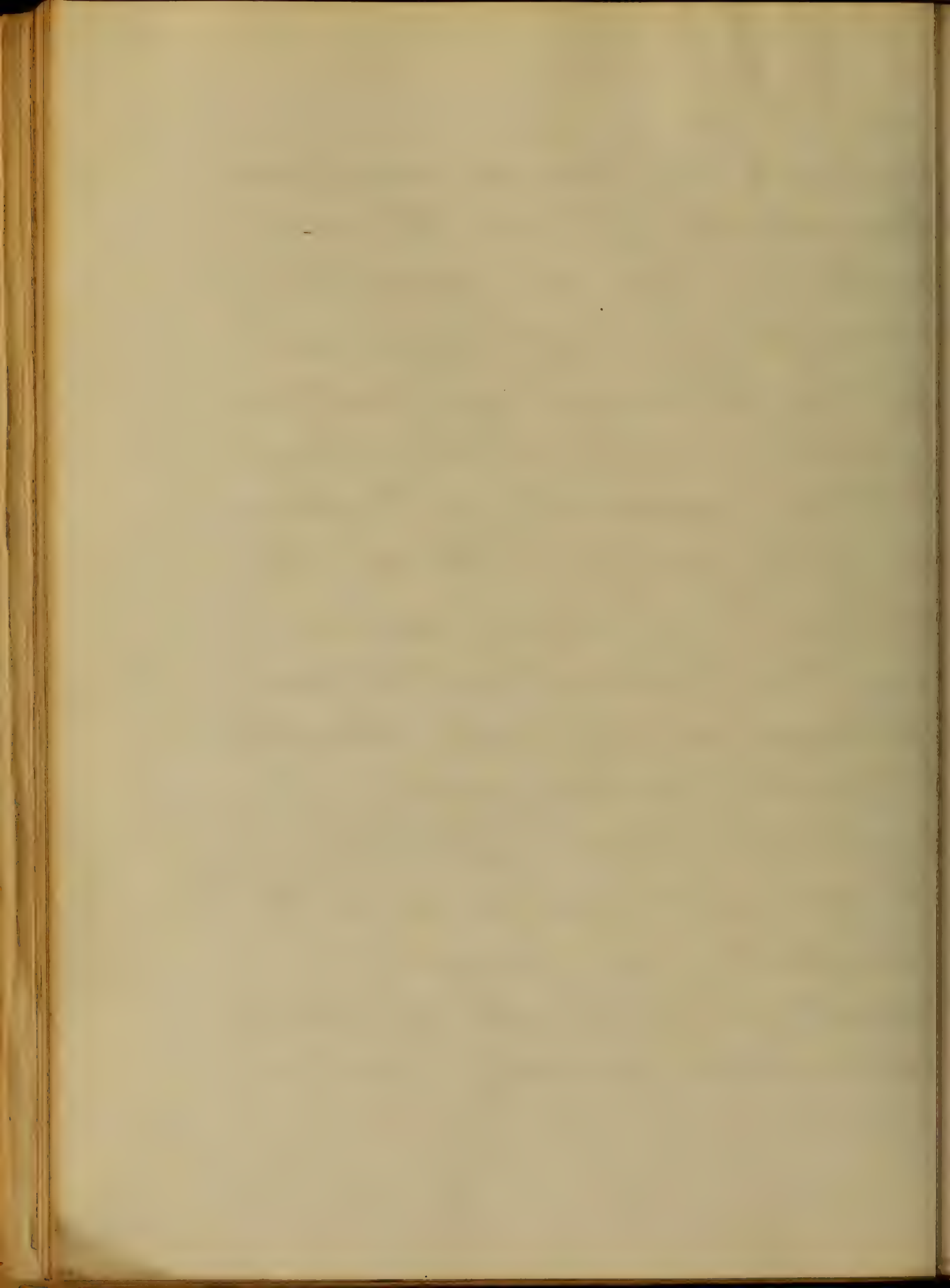
every fourth hour, and each
hour in the interval, half
a teaspoonful to one teaspoo-
nful of the following:

R Potas chlorat., ℥j- $\frac{ij}{4}$
F. Ferri Chloridi, ℥j
Syr. simplic., ℥iv- $\frac{ss}{4}$

No drinks are allowed for
a few minutes after its
administration as well as
after the use of the brush,
so as ^{not} to wash it away quick-
ly from the fauces. In three
or four days, if the case progress-
es favorably, these remedies are
employed less frequently, but
are not discontinued until



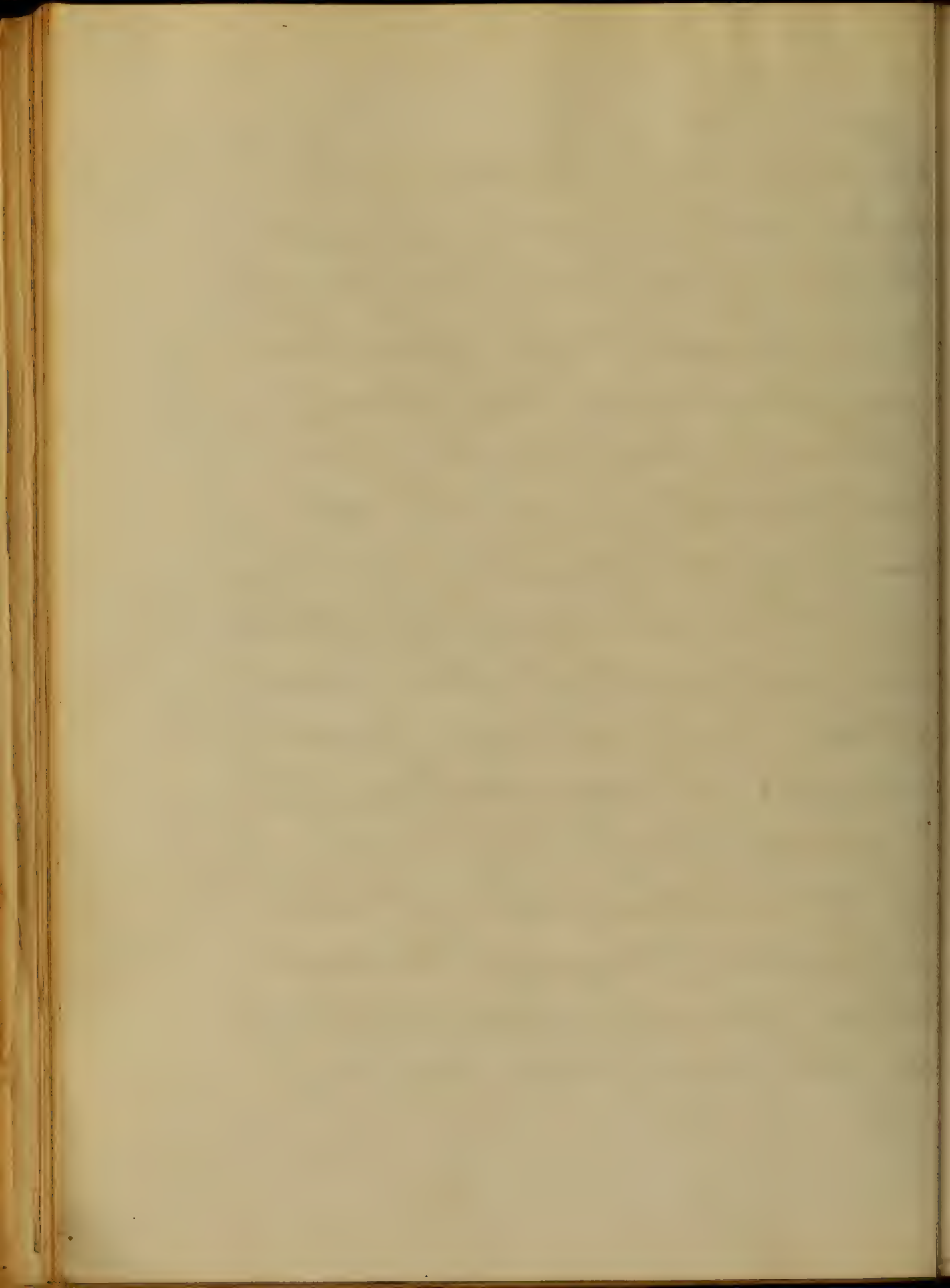
not only the pseudo-membrane
has disappeared, but the inflam-
mation has in great part
abated. For not infrequent-
ly the fibrinous exudation
reappears after it has been
totally removed, if the phar-
yngeitis remain. Hence the
necessity of daily examin-
ing the fauces until con-
valescence is well advanced.
When the inflammation has
begun to abate, and there
is no reappearance of the
exudation a gargle or
drink of chlorate of potash
and water usually suffices



for topical treatment.

Such is the treatment, substantially, which has proved so successful in the Foundling Asylum, & of which J. Lewis Smith in his last edition on the diseases of children, says: "From my observations of its effects, not only within this institution, but in my private practice, I can confidentially recommend it."

J. Solis Cohen M.D. of the Jefferson College of Philadelphia recommends Sulphur as the very best remedy



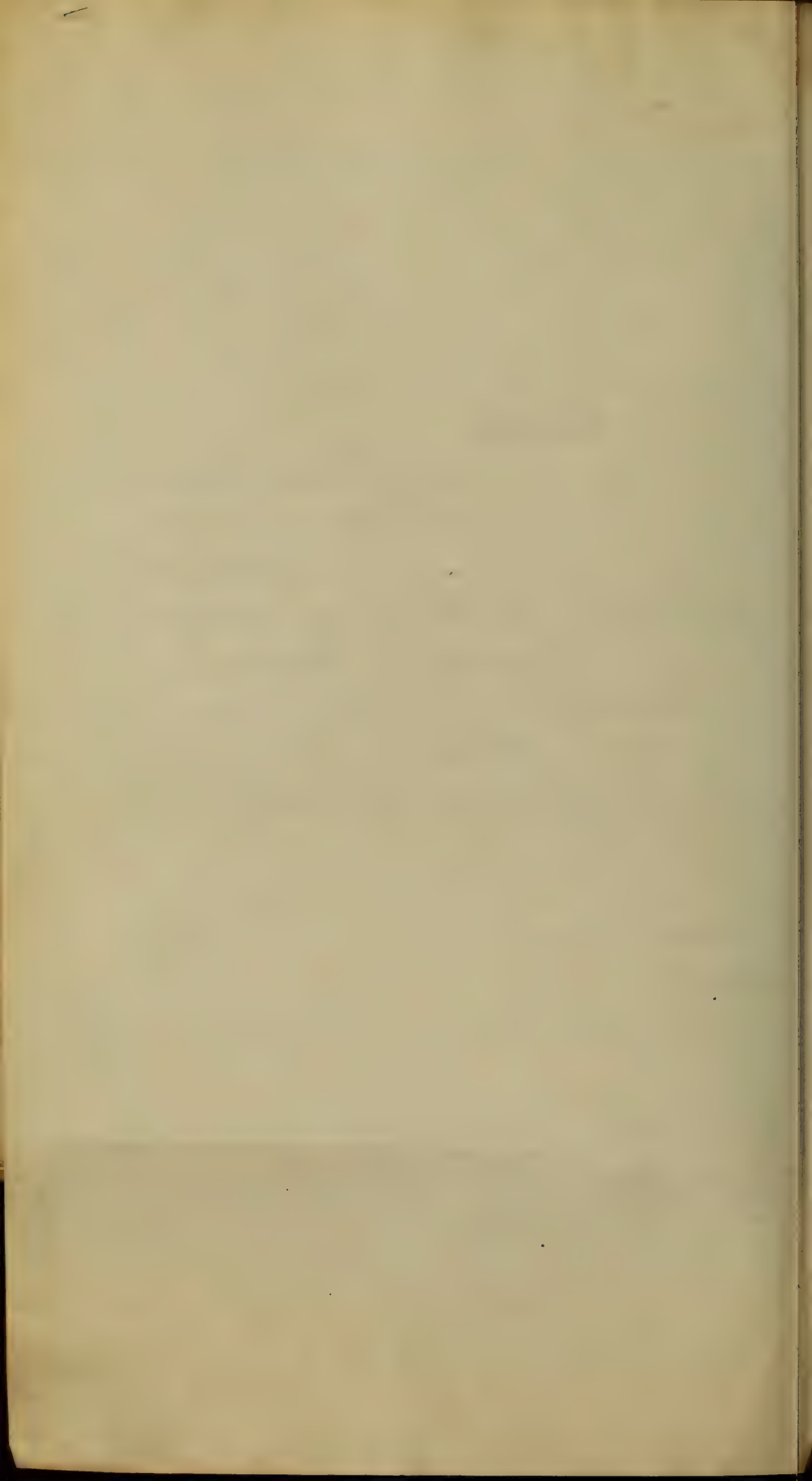
For topical application, he says that the curative powers of Hyposulphite of soda are due to the sulphur it contains, and as far as his observation goes it is in favor of sulphur, in the form of Sulphurous acidwater projected into the mouth & pharynx by means of a steam apparatus every two or three hours, for about ten minutes at a time.

It is important that the patient should have good nourishing food in a concentrated form, egg-nog, beef-tea &c.

Dissertation
On Cholera Infantum
By R. H. P. Ellis.

Respectfully sub-
mitted to the Faculty of Physic
of the University of Maryland
School of Medicine, for
the degree of
Doctor of Medicine.

Baltimore
July 1877



in Test.

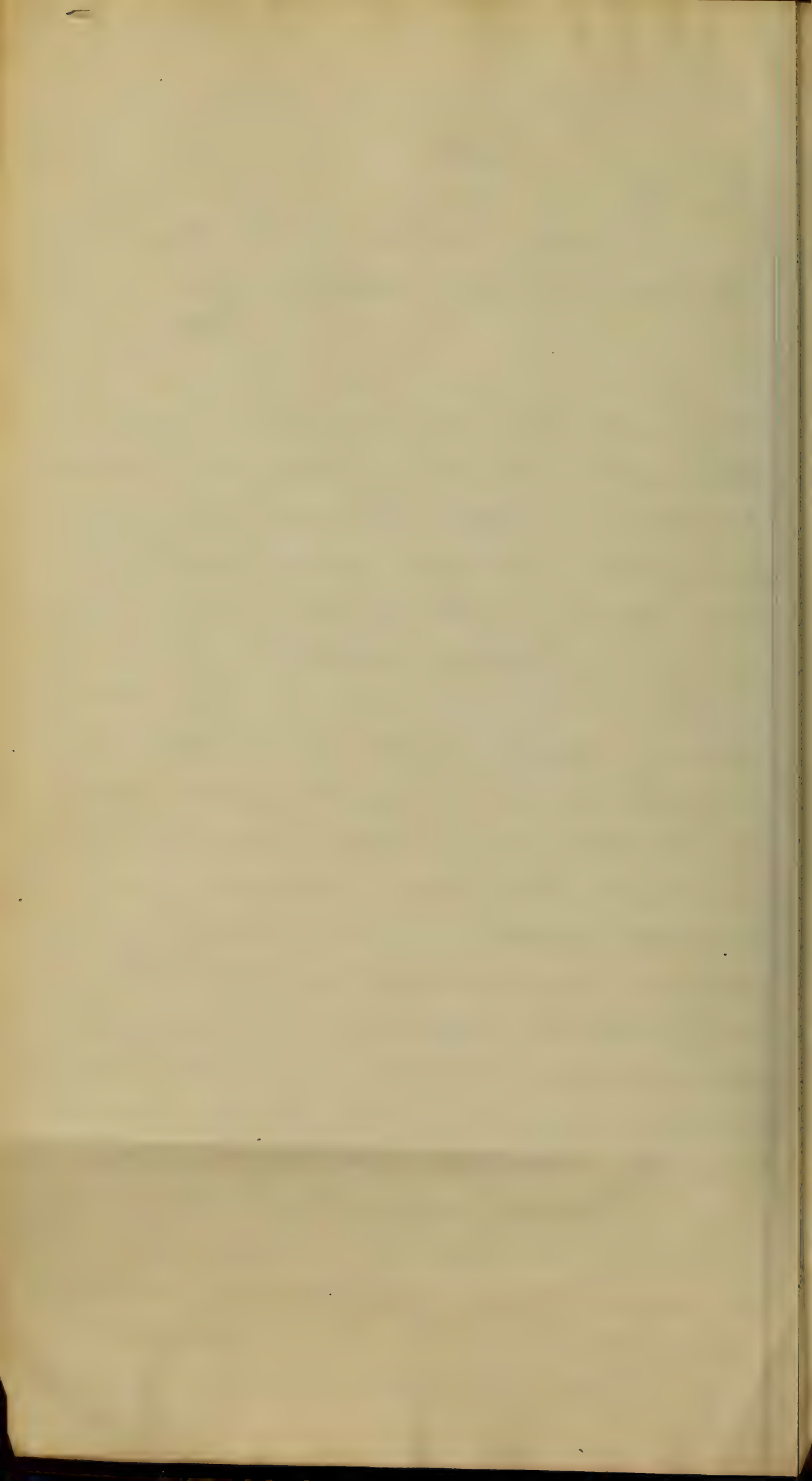
W. G.

Faculty of Physic, of the University
of Maryland, School of Medicine
Lecturer.

In compliance with the required task of preparing a
thesis, which you have so wisely imposed upon
Candidates for professional honours, I beg respectfully
to submit the following, which I trust may be
found pertinent to the subject selected, namely:-
Cholera Infantum.

This disease
popularly known as the Summer Complaint of Children,
is a perilous disorder of infancy, occurring most frequently
during the first year, or second, summer of infantile
life, and may be best defined, by an enumeration of its most
Characteristic symptoms, such as:- Copious purging
of thin serous fluid, or large watery and fetid evacuations, suc-
ceeded by more or less obstinate vomiting, cool dampness of the skin
the whole surface of the body, lividity of the tongue and lips,
intense thirst, pulse rapid, pinched countenance,
more or less complete Collapse - which may prove fatal, or be
followed, by reaction, and a subsequent simple or in-
flammatory diarrhoea.

It is almost exclusively a disease of the summer months, appearing
with the first heats of summer and ceasing upon the
recurrence of the cool weather of Autumn. It is



most frequent in large cities, especially in those sections most
 densely populated, and in some cities who are poorly
 cared for, this in these cities is badly certified.
 Cholera infantum proper is not so common as simple and infantile
 watery diarrhoea, most cases of which, have, according to respect-
 able authorities, been till a comparatively recent date, improperly
 grouped, under the common name of Summer Complaint.

It is said, to be of rare occurrence in Europe, and is considered
 unworthy of special notice by many medical writers of that country,
 who, have, according to Dr. Miess, ranked those cases which
 have occurred, among the cases of gastro-enteric irritation, or in-
 flammation, to which infancy is so commonly liable.

Its frequency and fatality in this Country makes it an object
 of great interest, and is held by the profession and people at
 large considered eminently worthy of special notice.

The attack of Cholera infantum proper is often preceded by
 diarrhoea, but the vomiting and purging ~~usually~~ occur in-
 stantaneously.

In fatal cases of short duration the vomiting ~~usually~~ con-
 tinues to the end but when it terminates favorably,
 or is protracted, the vomiting usually ceases leaving the diarrhoea.

In very violent and rapid cases, the vomiting and
 purging are incessant, the stomach is ~~usually~~ empty, and
 the patient drinks water.

The intestines are marked by great laxness and filled
 with more or less fermentive spines of the starch and mucus
 and if relief is not afforded prostration comes on with
 cold, and cramping action, fixed face, eyes sunken and insensibility.



amounting finally to coma, and death may close the scene in three or four days, or even in twenty-four hours. More frequently, however, the case is protracted to two or three weeks, attended with febrile symptoms.

In such cases the pulse is frequent and weak and the surface of the body irregularly heated.

The fever is of the remittent type, the exacerbations occurring in the evening.

During the progress of the disease, the child becomes rapidly, the features sink and the countenance is an index to the suffering it endures. In more advanced cases the mouth is

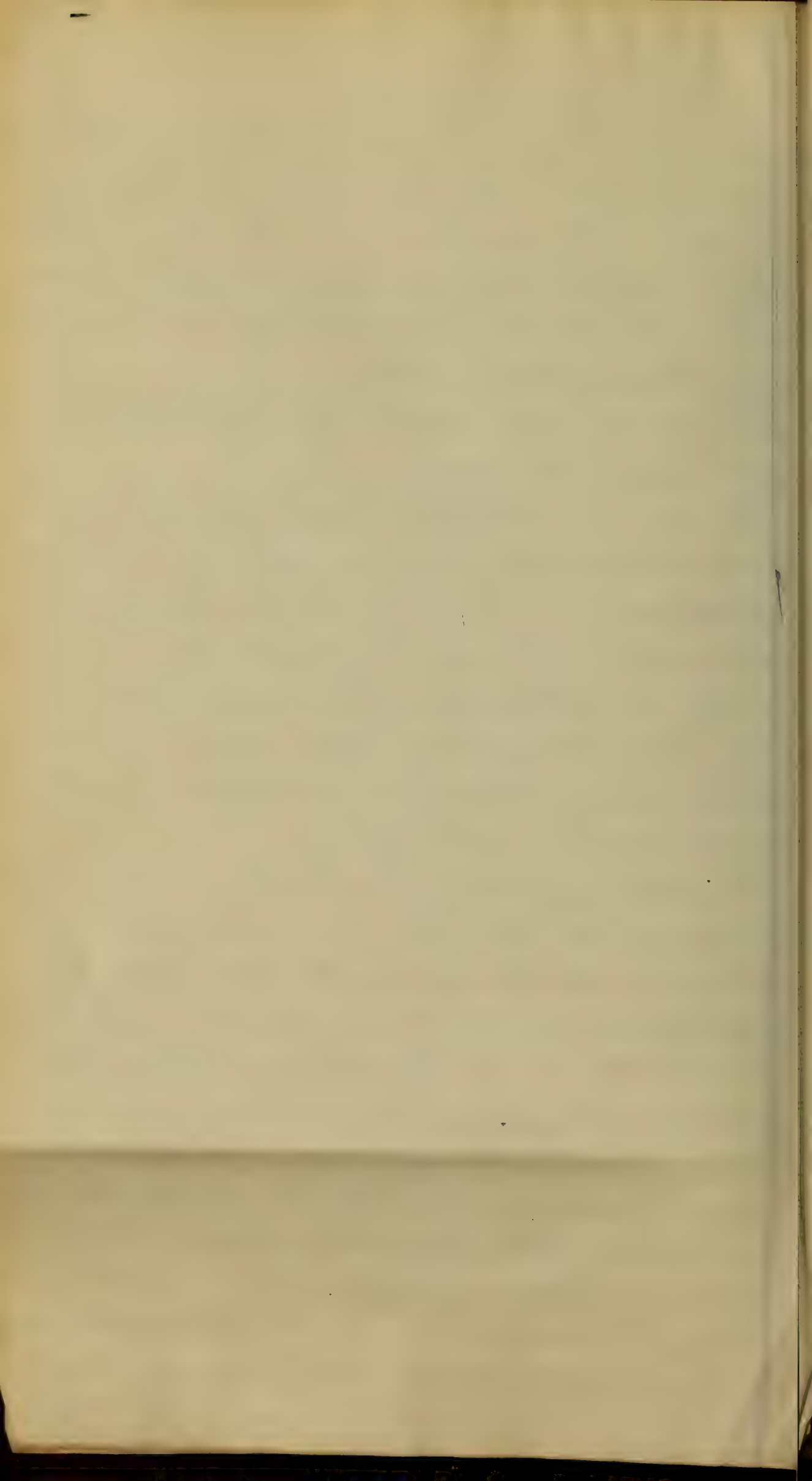
ruvid and aphons, and the Circulation languid.

The child is often very restless, uttering moans and plaintive cries. Finally coma sets in and the sense is frequently closed, by convulsions.

Throughout an attack the stools are usually scant consisting almost entirely of thin serous fluid.

The most important characters of the stools in this children infirmum are their fluidity and quantity. "These two characters" says Dr. Meigs & Pepper "more than the vomiting or the nature of the discharges in any other respect are the specific signs of the disease, and by the degree in which they are present, do we recognize the disease and usually determine its extent."

The stools vary in character from a watery colorless and inodorous fluid, to that of a yellowish or brownish fluid, containing a considerable amount of



These peculiar contents of a vomit appear also in
of the vomiting of some cases to twenty in local portions.

The matters vomited usually consist at first of the
ordinary contents of the stomach, food and water but
soon may consist of water or the medicines taken.

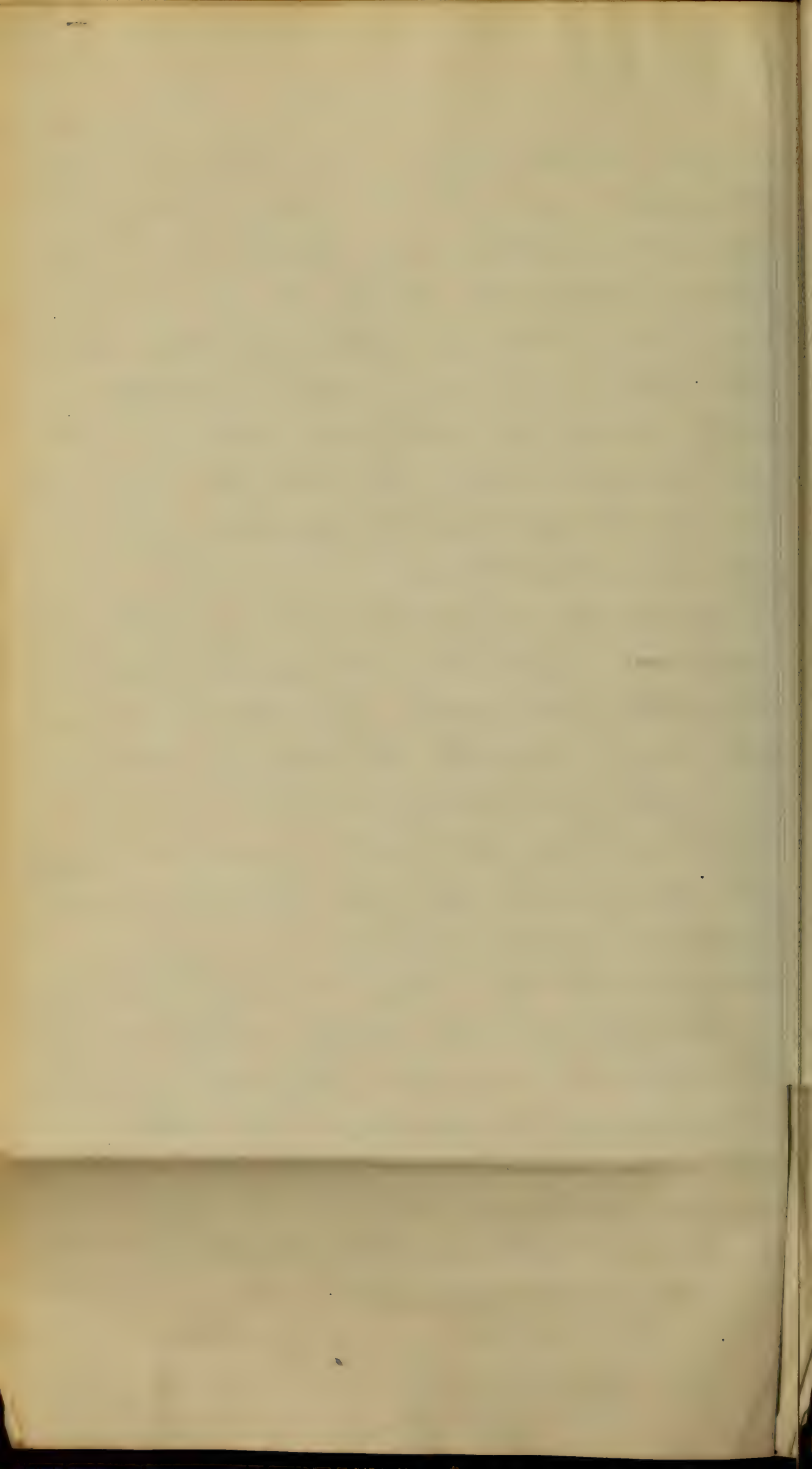
The appetite is lost or very capricious but thirst is
usually extreme and constitutes one of the most notable
phenomena of the disease. The pulse often rises to 130
140 or 150 per minute but the temperature does not in-
crease in proportion.

The copious and frequent discharge per rectum
and orom, if unchecked, soon precipitate the child
into a state of utter prostration, from which reaction re-
action may be impossible, the child dying comatose,
or with slight convulsions.

In favourable cases the sickness ceases to be so violent
after two or three days; the stools are less frequent
and thicker in consistence; vomiting ceases and food is re-
tained and the child, though the subject of a severe
diarrhoea for a few days, gradually regains health and strength.

Often however, the disease is not entirely abated and it re-
sists till the recurrence of cool weather.

-s of Cholera infantum, are evidently of the same nature
; are the same, as those of inflammatory diarrhoea.
; in the phenomena developed being due probably to
'ence in the age of the subjects exposed to their
and the power of resistance offered, or perhaps
different periods of infancy or childhood.

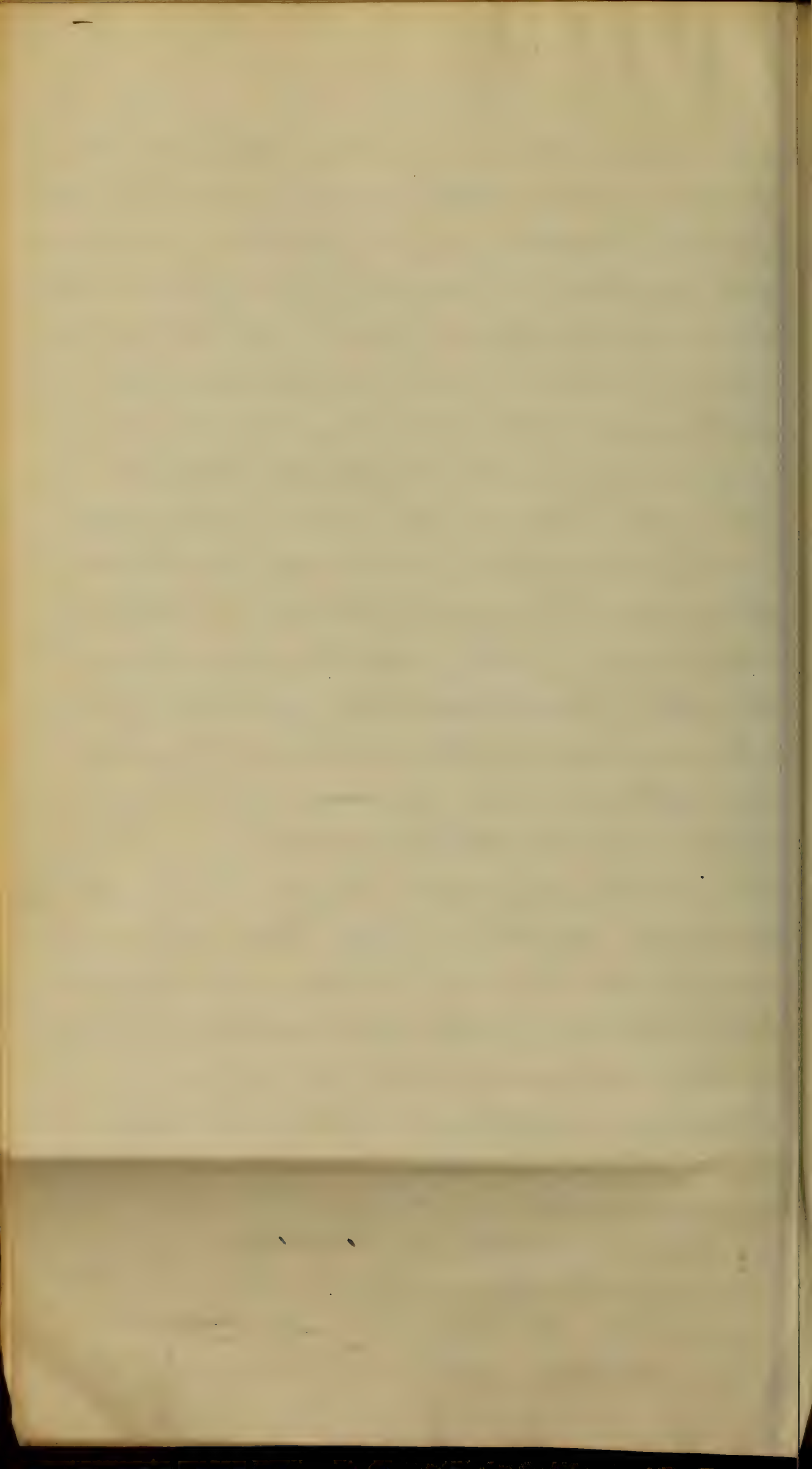


The two most important and fruitful causes are probably, improper ventilation and the suspension of summer. Improper ventilation may consist in an unhealthy condition of the mother's milk, or more commonly in the administration of some improper artificial food, of which, the kind most injurious is that which is composed in a large proportion of starchy substances which are allowed so trustfully to enter largely into children's diet. Weaning the Child from the use of its mother's milk (which cannot be done with impunity between the months of May and September) to that of artificial food, or the improper administration of the latter; the use by accident, or otherwise, of acid milk, unwholesome vegetables, fruits berries &c, will often bring on the disease, in a few hours, convert a mild diarrhoea into true Cholera infantum.

These results are particularly liable to be seen, and impudens or accidents, in large Cities, where being numerous, the hygienic conditions are most favourable to the production of the various intestinal diseases in their most severe forms.

Trussard, on account of a system of diet disagreeing to the digestive powers, recommends that children be confined, almost exclusively to the breast, until after the first dentition is completed.

Observation has taught that children fed only on artificial diet from birth, are especially liable to be attacked, and indeed rarely escape.



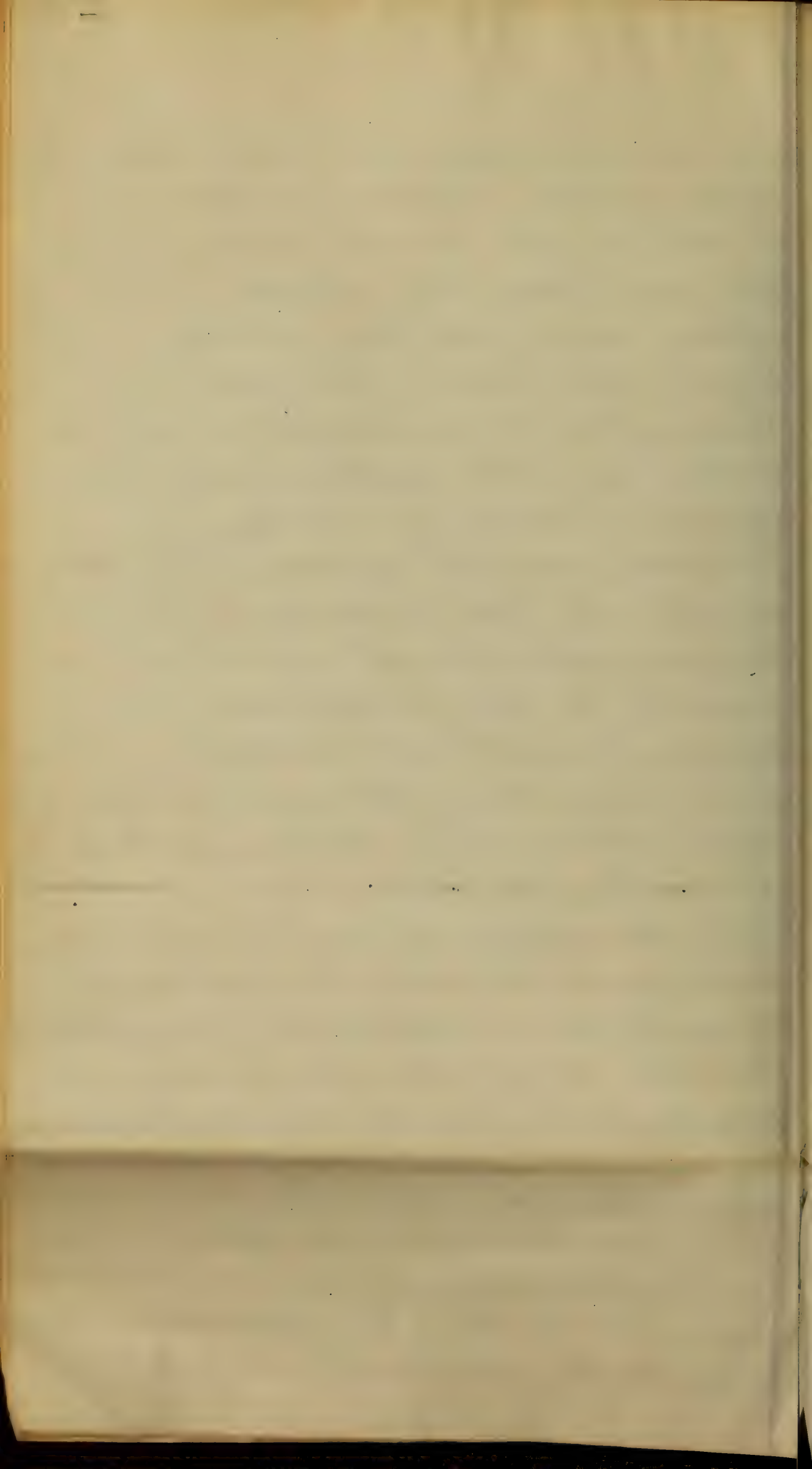
some form of intestinal inflammation, either acute
diarrhoea, Cholera infantum, or enterocolitis,
or what is not uncommon the three may be
more or less blended with each other, but Cholera
infantum assuming the form of a more or less
Chronic enterocolitis, or vice versa.

Excessive feeding, is also a prolific cause of intestinal
disorders, hence the quantity, as well as the quality
of the food should be carefully observed.

The stomach, during the early months of life is intended
and fitted, only for the reception and digestion of the
thin natural milk of the mother, hence the use of food
prepared in too thick, or rich a manner, such as
preparations of rice of too solid a nature, or of oat meal
gruel, in which there is little or no milk, is more
attended with more or less disastrous results to
the health of the Child.

Heat stands prominent as a most powerful exciting
cause, and when this cause, or these causes, operate
they may be, act with moderation, the resulting disease
that occurs will more likely be that of a simple or inflamma-
tory diarrhoea. But, on the contrary when the causes
act with a greater degree of severity, the case will most
probably assume the type of a true Choleraic disease.

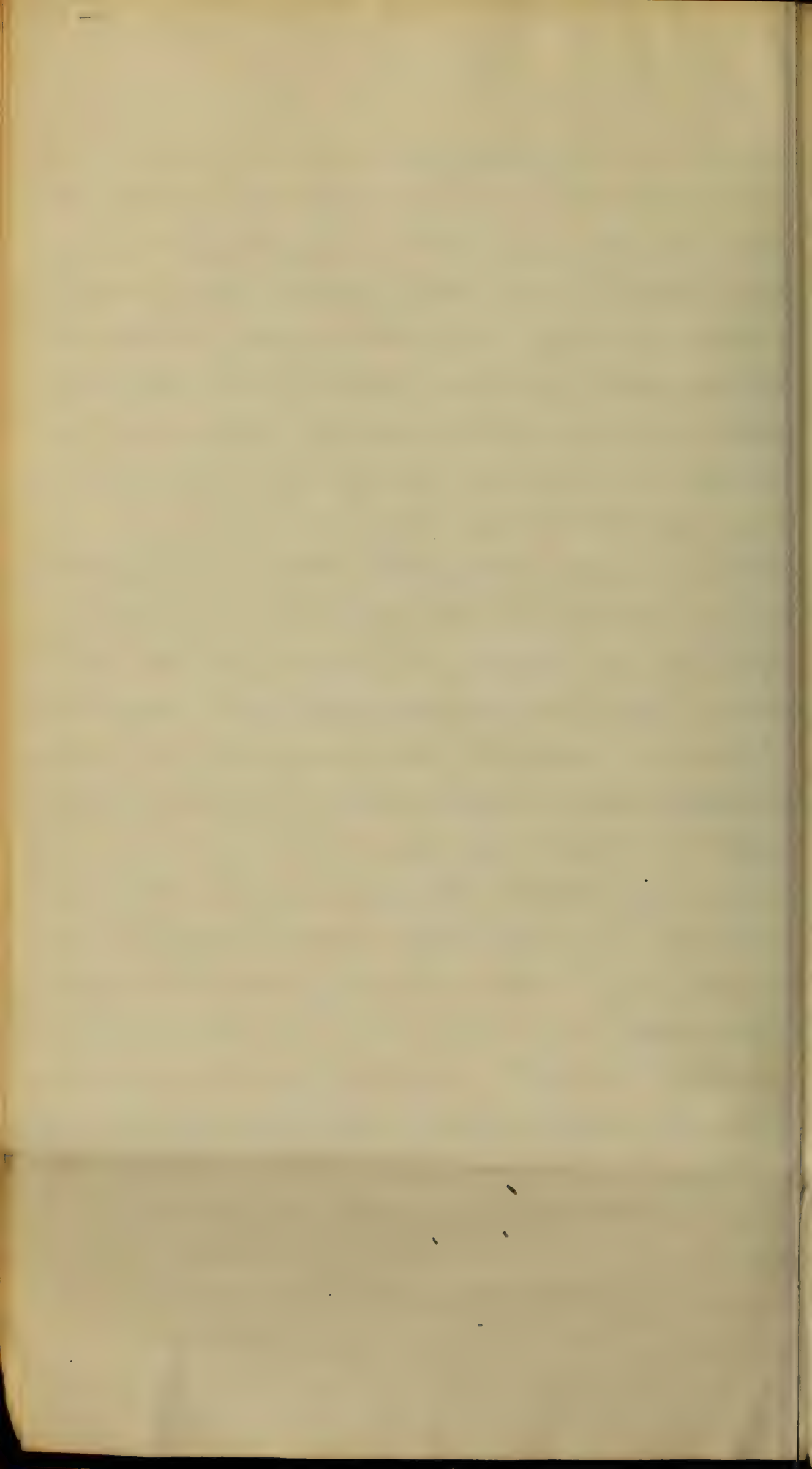
Thus, as Drs. Meigs & Peppi, when writing of the potency
of a high atmospheric temperature as a most influential
cause, say, "So long as the atmospheric temperature
is moderate, the resulting, the resulting diarrhoea will be of the



take the form of simple or inflammatory diarrhoea.
 But let the temperature rise to 85° or 95° then it is
 higher and happens occasionally during a summer
 and continues so for three or four days and the
 children previously well will be seized with the true
 Choleraic form of diarrhoea, whilst those who are
 already suffering with simple or inflammatory
 are prone to have ~~the~~ milder disease ~~change~~
 suddenly the Choleraic type".

While it is not believed, that heat is capable of causing
 Cholera infantum *per se*, yet that it is highly
 influential as a cause, is evidenced by the fact of its
 almost exclusive occurrence during the warm weather
 of summer, and that its frequency and extent bear
 a corresponding ratio to the degree and continuation of high
 temperature during any given summer.
 A union of atmospheric heat, with atmospheric circulation
 seems to favor its most extensive and fatal occurrence,
 very greatly augmenting both its development
 and fatality.

Dehydration, although a physiological process, is always considered
 a powerful predisposing cause. Its effects seem almost al-
 ways sufficient to produce some degree of intestinal dis-
 order and when brought in conjunction with other
 auxiliary causes, such as a high atmospheric temperature,
 improper food &c, the true Choleraic disorder is often
 developed. The general effect of all preceding causes
 is much intensified by the occurrence of dehydration.



Cholera infantum occurs most often and is most fatal among children of late settled habitations.

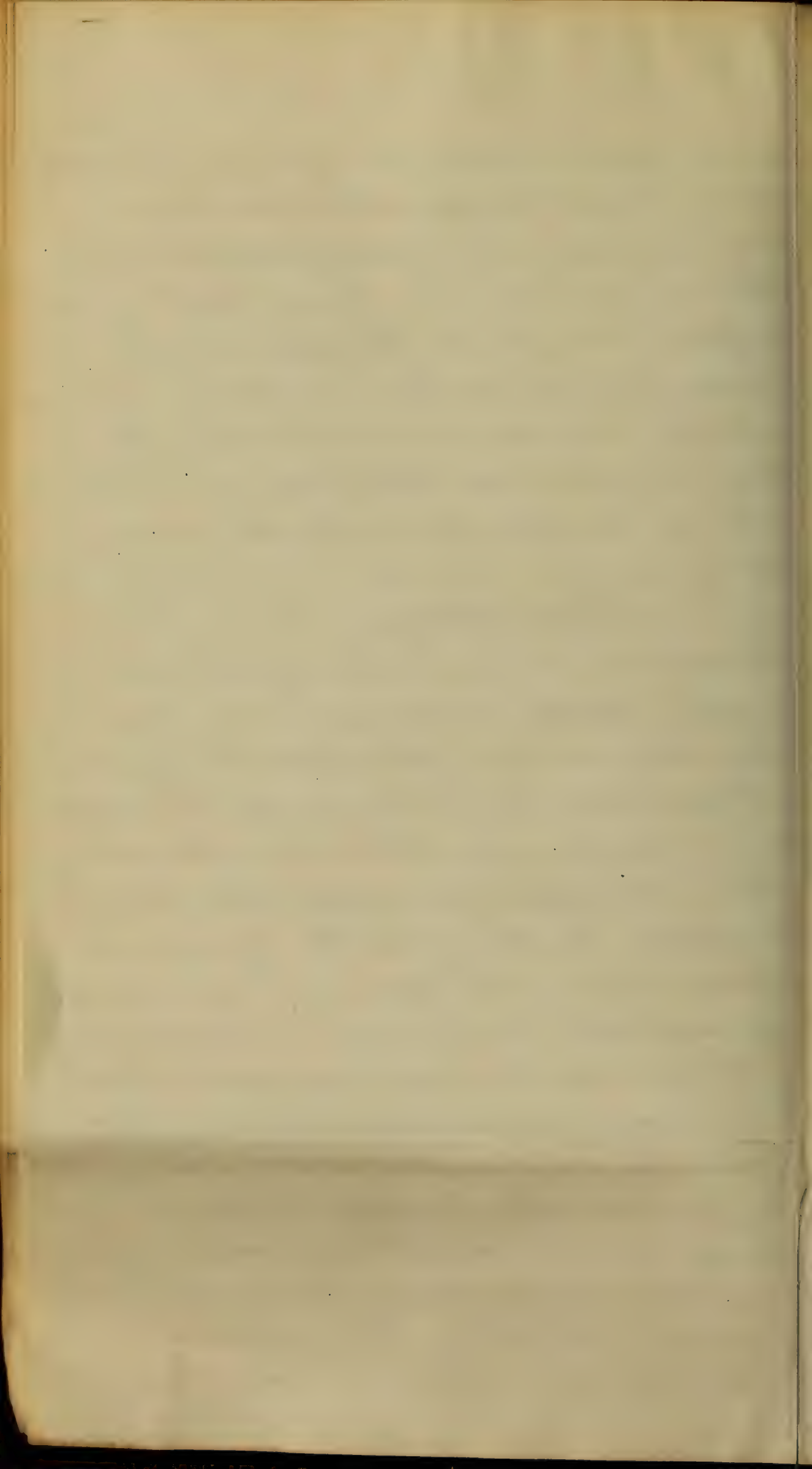
More children die from it during summer than at any other time, and when it occurs after the summer is completed, it is far less fatal than before.

Cholera infantum in the child is the analogue of epidemic cholera in the adult, and it is believed that the same causes that produce the former in the child will give rise to the latter in the adult when it is epidemic.

Morbid Anatomy.

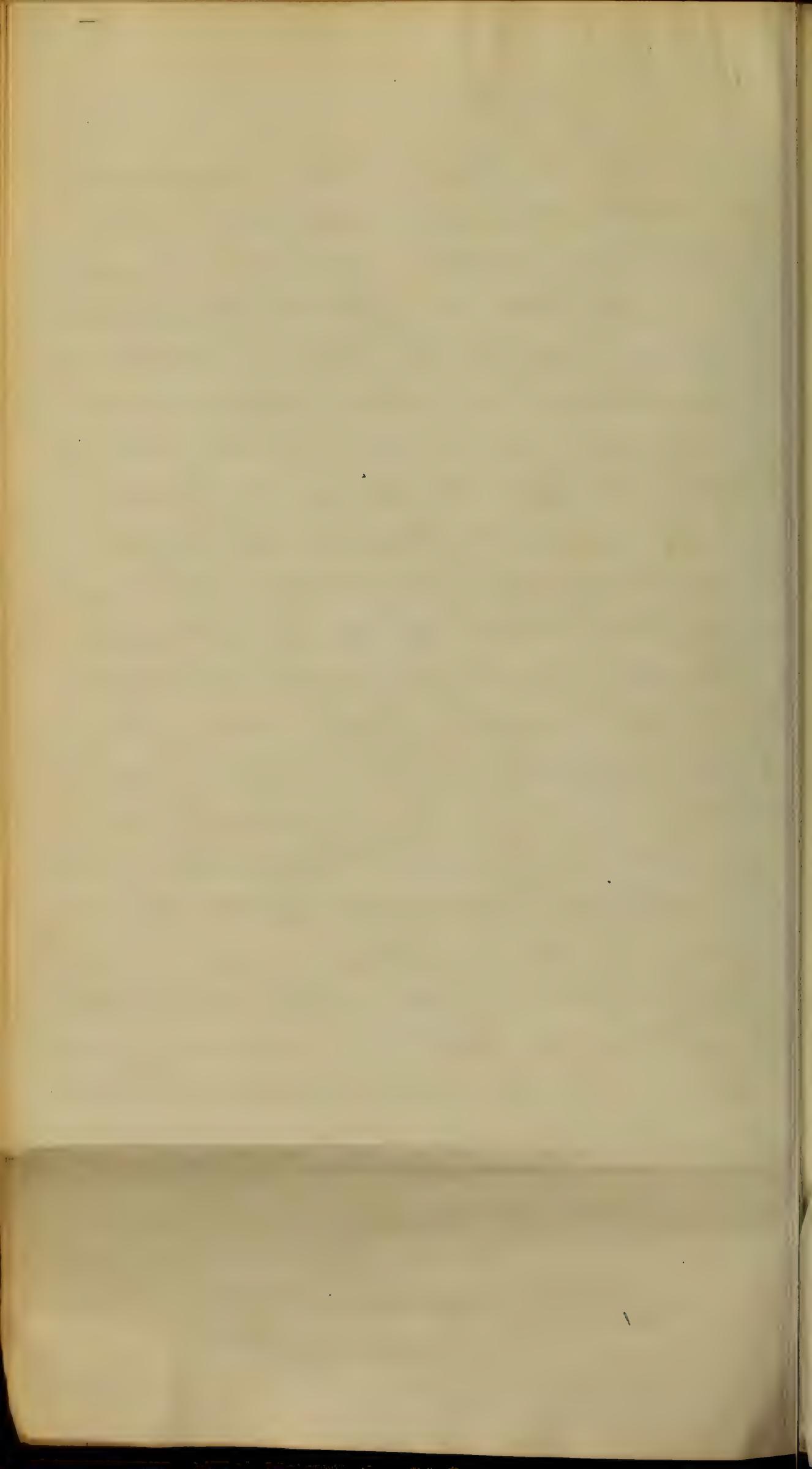
The anatomical lesions of Cholera infantum seem to be by many writers, considered and described as being analogous to, or identical with those of inflammatory diarrhoea. But if we regard Cholera infantum as a disease per se, distinct from other colitis which it certainly appears to us proper to do this, with this restriction, it is obvious, that the appearances here mentioned can not be the same. (The post mortem appearances might be the same, and yet it does not necessarily follow that the diseases are identical. I have erubid by the use of poisonous doses of arsenic or lime, arsenic, nitric acid, or of ductile phosphorus, especially in children, may serve to illustrate this fact.)

It frequently happens that the true choleraic lesions and its appearance during an attack of inflammatory diarrhoea, and speedily proves fatal. Now in such cases it would not be correct to attribute the pathological changes



present entirely to a morbid inflammation however the infla-
 matory process may be a result of the disease or
 with the changes wrought. Again, as a result of inflammation
 (typhoid), the attack may present the true Cholera
 symptoms, and to true Cholera infantum let us
 one, two or three - days, these symptoms may
 side, by passing into a more or less chronic enteritis
 of a high latter affection the child may die. Evidently in
 such cases, although the attack was that of true Cholera
 infantum, the morbid changes could not be properly
 assigned to this disease, for the child was the subject
 of inflammatory diarrhoea for some days, perhaps weeks,
 before death, and the lesions would of course
 be those of a more or less chronic inflammatory dia-
 rrhoea (Fig. - more or less discoloration of the lining
 mucous membrane of, with thickening and irritation
 of the walls of the large intestine, and sometimes ir-
 ritation of the mucous follicles.

The inflammation may extend into the small intestine,
 the lower end of the ileum being the portion usually involved.
 I cannot conceive how such a condition as Cholera infantum
 can exist, since it is so well known to be
 essentially of an acute character the symptoms passing
 rapidly. Hence the true and proper lesions of Cholera
 infantum would appear to be those observed after
 death, in those cases where the true Cholera
 disorder has appeared in the middle of the attack
 and proved fatal in the acute stage, that is the



it has been the form of suppurating discharges
 in such cases the type of inflammation being
 mixed, the only essential antecedent Cause being
 enlargement of the mucous follicles and to some extent
 of Peyer's glands, with possibly, any slight mark
 of inflammation of the living mucous membrane of the intestine.
 The liver is usually congested and enlarged, constituting
 hepatic enlargement.

The nature of Cholera infectiosa seems to be that of a
 gastroenteric catarrh, which is shown by its usual
 being those of catarrhs generally, viz: insipidation
 mentation, epidemic influence, and sudden variation
 of temperature; also by the analogy of the symptoms.
 Concerning the cause of the state of collapse more
 theoretical attempts have been made to explain the
modus operandi of various Causes in its production.

The excessive drain of serous fluid from the intestinal
 canal, evidently has much to do with the progress
 of the disease and the rapid exhaustion of strength,
 but this is not now regarded as the direct cause
 of collapse, because the latter sometimes occurs when the
 discharge is but scanty.

Collapse is most probably due, indirectly to the morbid
 condition of the great sympathetic and vaso-motor nerves.
 With the understanding, that the triplicate, or great
 sympathetic nerve, controls, in a very great degree,
 arterial action, by regulating their calibre, inducing con-
 traction, or allowing relaxation of their muscular coat.



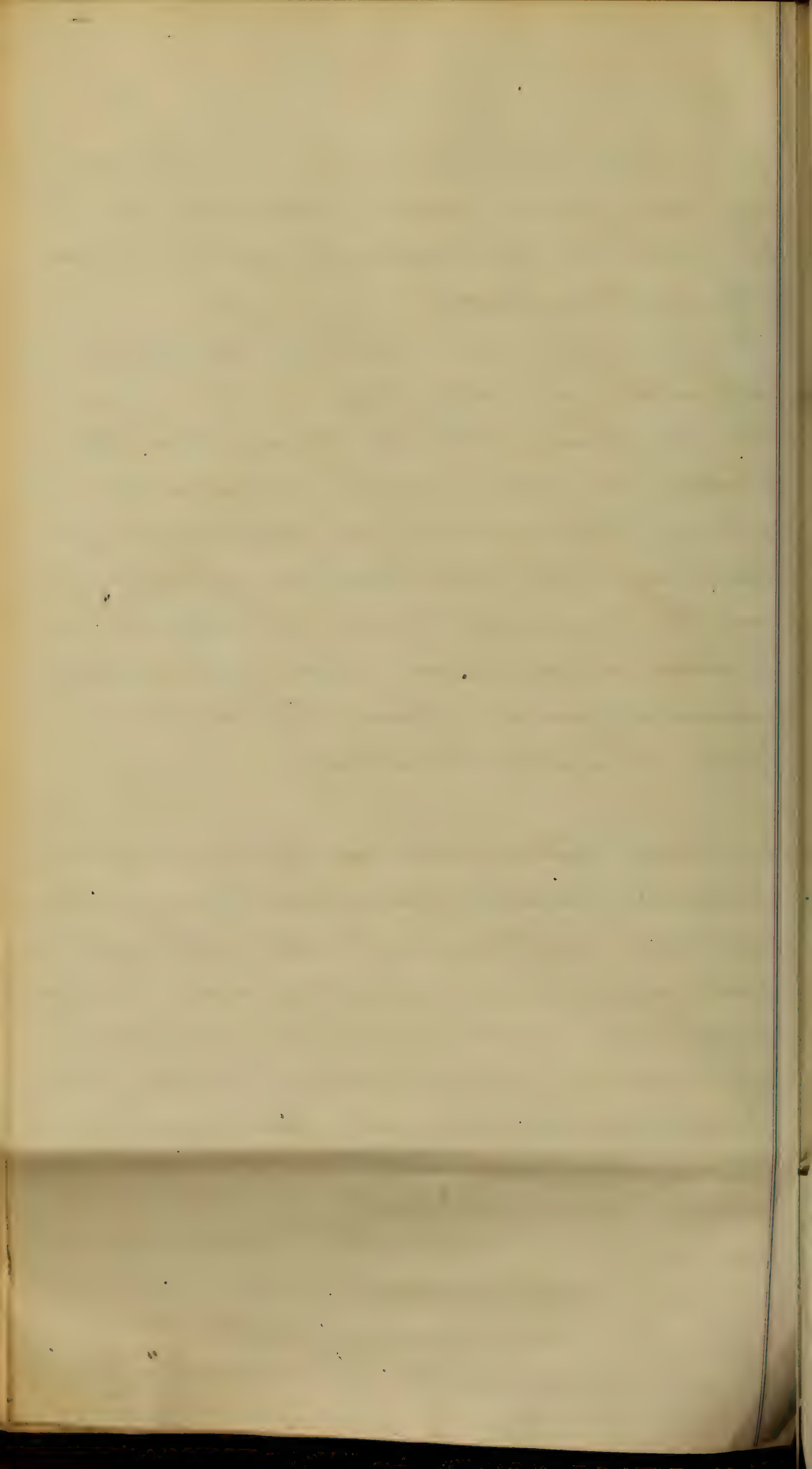
... may be ... of the alimentary Canal.

In this way we can account for the ... cold skin and extremities.

It is also believed, that the ... increase secretion and discharge of ... which always produces hypersecretion and ... flux from mucus membrane.

mis.

- Cholera infantum presents no difficulty of diagnosis to any one acquainted with its ordinary symptoms, and mode of progression. The most marked symptoms which, if recognized, will plainly indicate the disease present, are: frequent and profuse fluid stools often mixed, at first, with lumps of undigested food, mixed with ... severe and obstinate vomiting; rapid exhaustion of strength; rapid pulse with little or no fever; sweating, or actual effusion of ... rapid pulse, and diminished ... secretion. An intelligent recognition of these



symptoms, with a view of the manner
in which, and conditions under which it may
occur, will make the diagnosis plain and
confined to the intelligent physician.

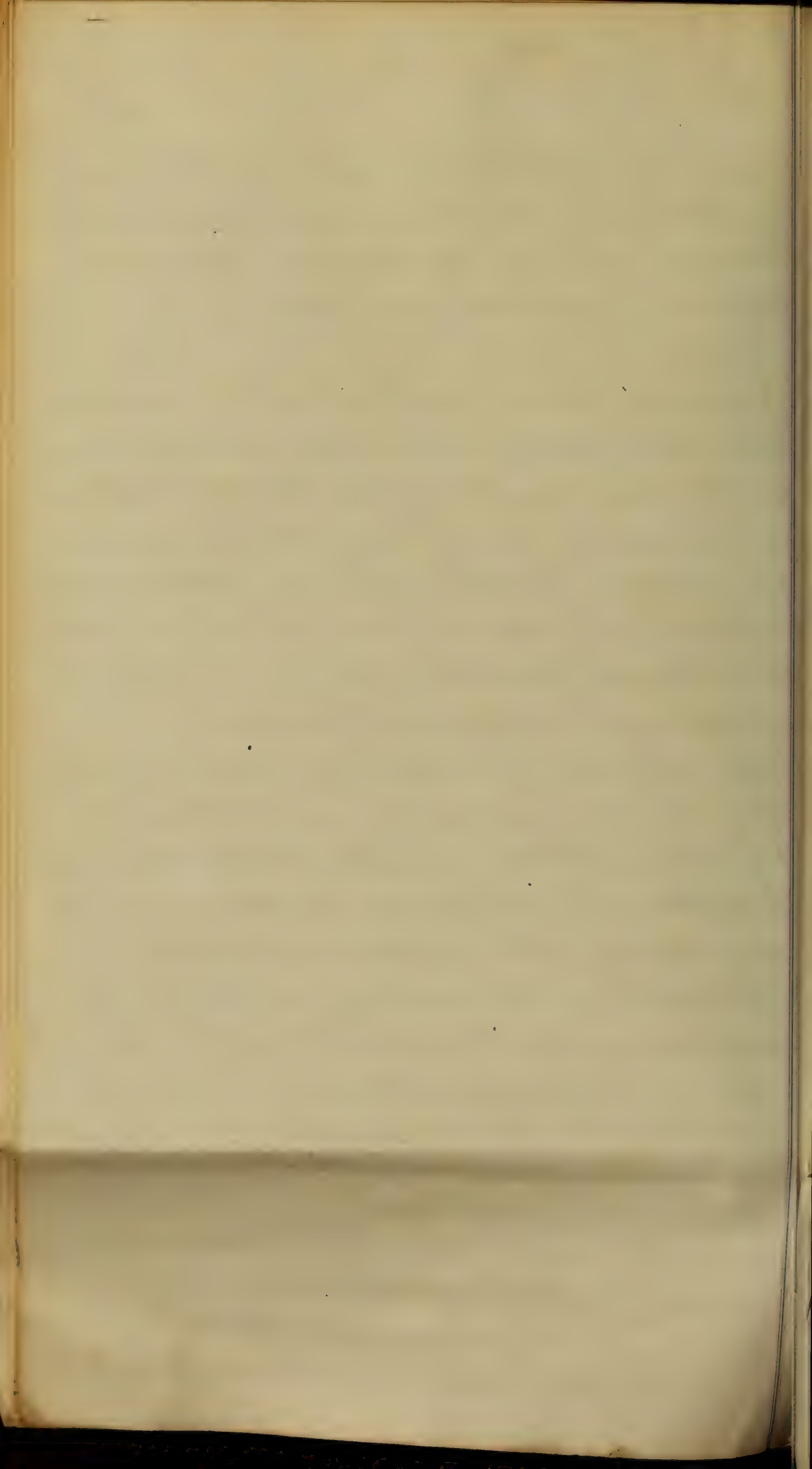
Cholera infantum is well known to be a very
and fatal malady, under unfavorable circumstances,
and its immense fatality in the City of Boston,
as elsewhere, especially during the past summer
was startling. Collapse, which either threatens, or
occurs to some extent, in almost all cases connected
with the true choleric disorder, is a most
formidable and dangerous condition.

The occurrence of Collapse depends in great
measure upon the surrounding hygienic conditions of
the child, its age and state of dentition, its
general vigor, together with the skill and
experience displayed by the physician in treatment.

The most unfavorable conditions are, early age,
recent weaning, hand nursing with improper
and a feeble constitution.

Children who live in the country, or in rural
healthy parts of cities under good hygienic conditions,
and who were in good health previous to its attack
are the most likely to recover from, or escape entirely
the dangerous condition of Collapse.

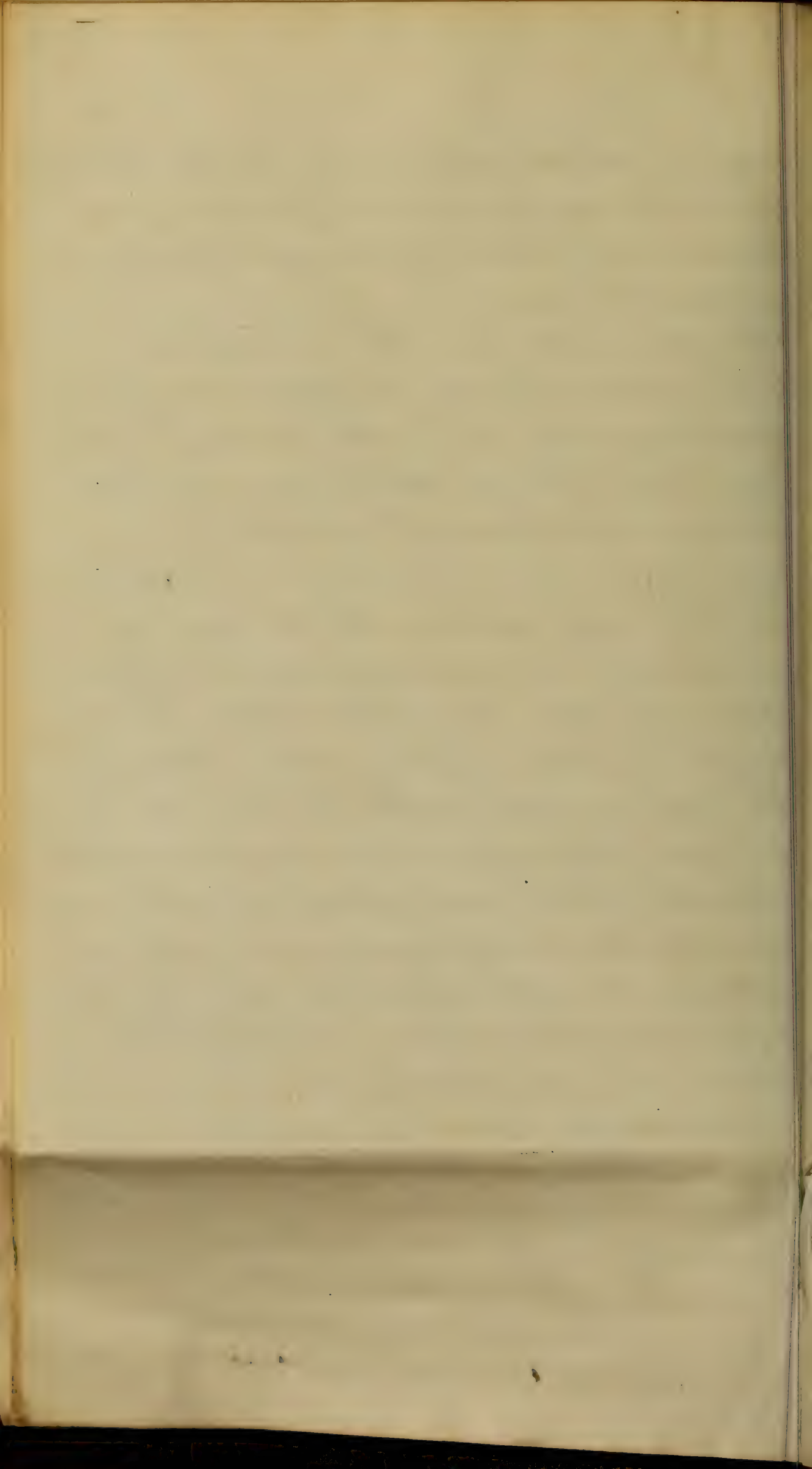
But when the stools are very frequent and fluid or
scanty and green, mixed with blood and attended with



business; when the abdomen is tympanitic the
 peristalsis is slow, and the temperature being
 elevated, the prognosis is in general
 unfavorable.

When the symptoms point to a favorable issue,
 there is cessation of vomiting; the stools become
 frequent, and finally return to their normal condition;
 sleep becomes quiet, and appetite returns, and perfect
 health and strength may be expected.

Nowhere in medicine is, the well-known axiom
 which says, "An ounce of prevention is worth
 a pound of cure," more applicable, than in the
 prevention of Cholera infantum, and its treatment.
 This being recurrent, with the well known fact
 of its great prevalence in our cities during the hot months
 of summer, should induce parents, if possible to
 remove their young, and especially teething children, to
 the country during the hot months. This with proper
 care and attention to alimentation, constitutes the best
 prophylaxis. But unfortunately, the great majority
 of children, whose circumstances, and position in life
 are such that subject them most to the ravages of the
 disease, are unable to do otherwise, than remain in the
 cities during the hottest months. When this is
 the case, they should be taken into the open air, or to
 air, as much as possible, and their diet should
 be kept strictly clean and well regulated, with



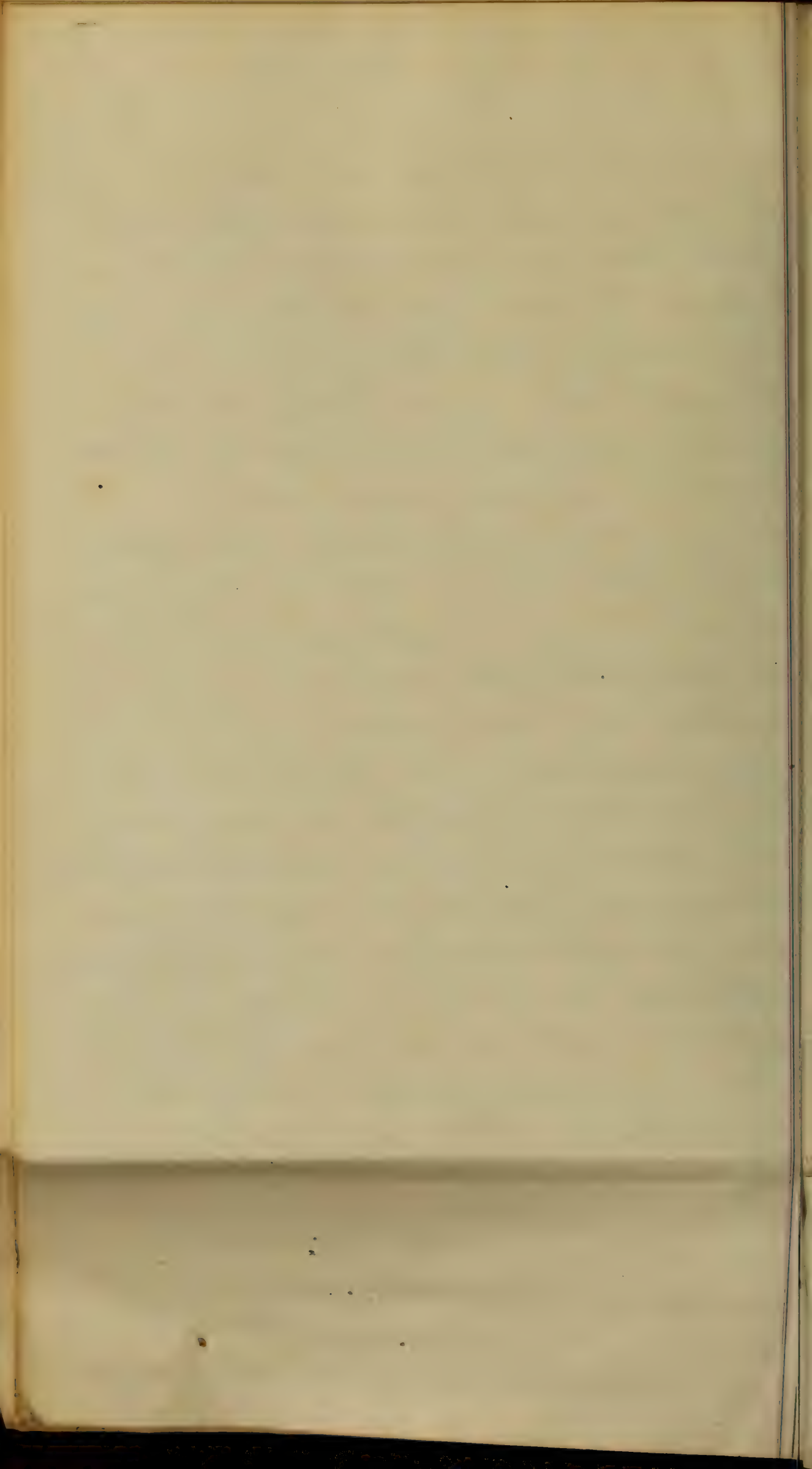
Careful attention to their food and clothing.

It is best for the child to be kept at the breast till after its second summer has passed, the longer the disease runs much less after the first.

But if weaning must take place, it should be done before hot weather sets in, in order to escape the danger of a change from the use of its mother's milk to that of artificial food during warm weather.

The food for these children who are compelled to be weaned, by hard nursing should be simple, pure and should consist, during the first year of pure milk properly diluted with water, and containing small amounts of ferussious substances, such as; iron, oat-meal, arrow-root, or rice. They may be permitted being occasionally allowed to suck sweetened beef, chicken or fat meat. Small amounts of soft soup, and meats, finely minced, may be allowed, after the first year, but the diet should consist chiefly of milk until after the first dentition is completed, and of it any time during this period. The gums often grow so irritable, and become loose and swollen, it may be necessary to incise them. Clothes should always be light and comfortable. By judicious observing these hygienic points of diet, dress, and open-air exercise, much may be done to prevent the disease.

In the medical treatment the physician must decide for himself as to what kind may be the best effort, according to the stage of the

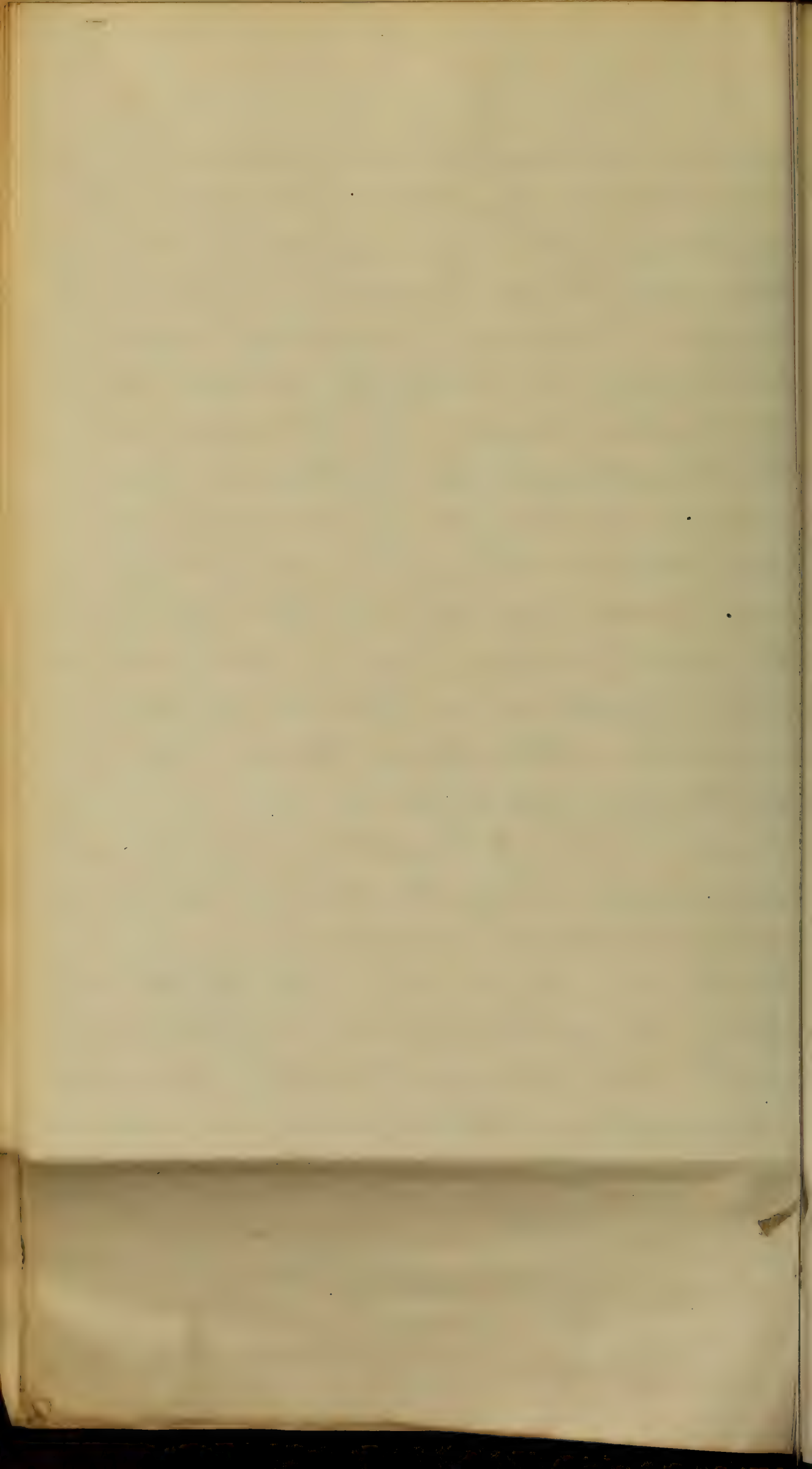


circumstances, well conditions of the patient when seen.
 If the child is vomiting all and with profuse watery
 diarrhoea (which usually contains at first and soft
 curdled milk, lumps of undigested food &c) with stiff
 ing pain in abdomen, and especially if attended
 with vomiting, the child may be considered in the first
 stage of cholera infantum. Now if it could be ascertained
 that this condition had been brought about by some
 indigestible food taken, then it would seem most ra-
 tional, to remove this source of irritation by the use of
 a mild cathartic, say grs. $\frac{1}{2}$ of Calomel followed by a
 little Rhubarb, or what is probably better, an aromatic
 spiced Symplicial Rhubarb or a half drachm of ginger
 with oil, two or three drops of Laudanum according to the
 effect desired &c may be given.

If acid is shown to be present in excreta by a
 small and green color of the stools, carbonate of mag-
 nesia should be added to the Rhubarb.

In a short time, say an hour or two after the admin-
 istration of the cathartic, if the stools are still present
 and thin, Chalk mixture with tincture of Krameria, with
 Laudanum or pargenic would probably be a suitable and
 efficacious combination as follows: one teaspoonful of
 mixture with ten or fifteen drops of Krameria, and one
 or two of Laudanum in one dose every two hours.

A Chalk mixture may be given very often in the profuse case, but
 may soon evacuate, but when the case is severe the
 addition of the Krameria as above, will increase its efficacy.



its subcarbonate of bismuth is also used and may be given in powder, alone or with water or suspended in gum. It is also very commonly given with chalk and opium in powder in the form of one or two grains. If these means do not arrest the diarrhoea condumina may be given.

Acetate of Lead is highly recommended for the purpose of controlling diarrhoea being both astringent and sedative and the following would be a good formula for its use in this affection.

℞. M. et S. Raspoofe may two hours at a year old.	}	R. Plumbi Acetate gr. ii
		Acid. Acet. m. ii
		Aquae Dist. ℥ss

This should, however, be preceded in time or time by a full dose of opium.

As soon as the stools cease to occur, say it is not intestinal, the lead should be given less frequently, and when the discharges cease to be especially profuse, it should be discontinued, and something more simple given instead in order to avoid its toxic effects which might occur.

Under these Circumstances and Conditions a very good remedy would be a decoction of logwood or prepared in case of sea or the infusion of the latter, a decoction in milk is recommended.

For the same purpose bismuth and chalk combined with purgative may be given.

When the diarrhoea has a dysenteric tendency, and particularly if the stomach has been irritated

Location -
Species of
mount of

as as not to have retained very well the medicines
 from a combination of *Acid Sulph. Spum.* and
Lactin Opium and *Syrup. Mucosus* is highly
 spoken of as follows:

No. 18. Transposed every two hours.	{	R. Acid Sulph. Spum. Gutt. vi-xii
		"r. Opium Gutt. vi-xii
		"r. Mucosus ℥i
		Aqua. Fluviat. ad ℥ss.

Loboul has been much used in the early stages but
 is now discarded by some, still it would
 be very properly indicated when there is evidence
 of retention of bile, and in a few cases where
 I have had the opportunity of a student of observing
 its use, it seemed to do good by inducing the
 flow of bile.

Generally, by the intelligent use of these medicines
sedatives, absorbents and astringents as they are
 variously indicated and required during the
 different phases of the disease, with a liberal
 view, strict attention to the alimentations and
 general hygienic conditions of the child will
 suffice to check the disorder, and place the
 child in a favorable condition to recover.
 If, as sometimes happens, vomiting is strongly
 obstinate so that the stomach cannot retain
 such medicines as we wish to give, and
 the special object of creating diarrhoea and
 promoting surface action, recourse may be

Treatment of
Croup?

has to remain however in order to allow
the expansion of the stomach.

Diagnosis of treated and vital, in the presence
of about two parts meal to one of yeast
may be applied to the epigastrium or
mit steeped in brandy, or Colopinsone
or powdered black pepper may be used.

At the same time very small draughts of lime water and
milk in equal parts, say in teaspoonful doses, may be given
or weak mint pulp, ice cold, or what is usually called
a small piece of ice may be sucked.

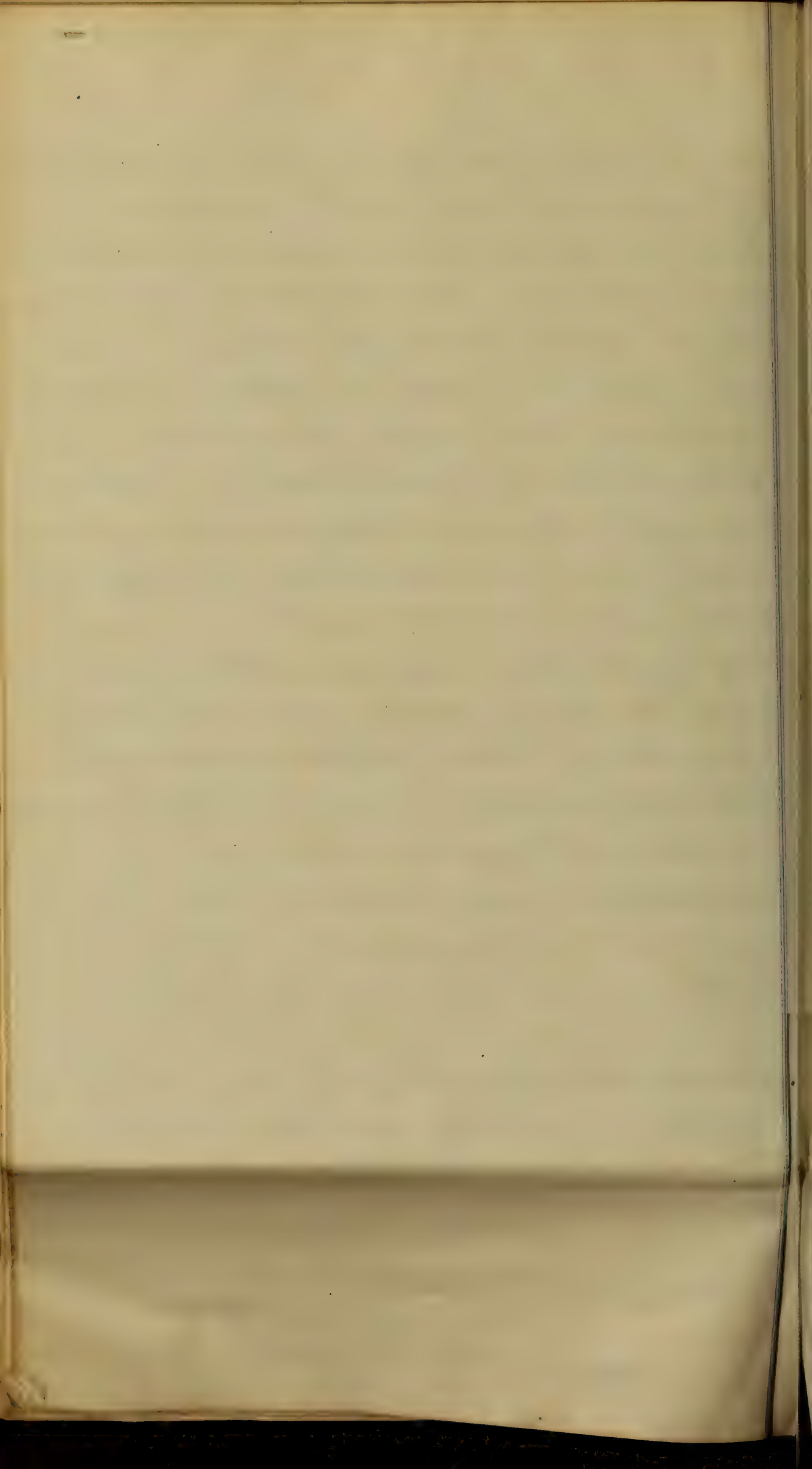
Vomiting may often be very successfully controlled by doses of
two or three drops of aromatic sulphuric acid with four
or five drops of solution of morphia, in ice water every hour.

For the same purpose the following is highly recommended

Combination;	R.	Sig.	morphae Sulph.	ʒss
			Acid. Sulph. dil.	ʒi℥x.
Mist. S. Teaspoonful			Carosca Cordial	ʒii
every hour or two at			Aqra —	ad ʒii
six months old.				

Sometimes notwithstanding the most judicious treatment
the child is precipitated into a state of collapse.

When this is the case the treatment must of course be changed
to suit the condition. During the condition the stomach is
usually empty and smaller in quantity, and all the vital
functions are more or less unning. Here the object of
the physician is to aid the efforts of nature to bring
about reaction. For this purpose the use of



drop loses of the ... in ice water.

Ice water should be constantly given, even though it is often ejected for if this should be lost a very small amount retained it may do good by aiding in restoring the thickness and condition of the blood, caused by the excessive escape of the liquor sanguinis.

Water may also be used if needed, when the circulation is checked. During collapse, opium should be given, if at all, only at first, and in the smallest dose.

The following prescription, ^{would} probably be an appropriate and efficacious stimulant to paralyze motion.

- R. Liq. Acid. Sulfuric. Gutts. XXX
- ℞s. Anisi - Cajuput. Juniperina Gutts. XXX
- Ether ʒi
- Tinctura Cinamomum ʒi

(Of this two drops may be given in a teaspoonful of ice water every fifteen minutes.)

But little food can be taken during collapse, small amounts of wine whif, or thin Chicken broth is probably all that can be given. If the extremities become cold stimuli should be applied abundantly and without intermission.

If reaction be brought about, there need subsequently be but little to be feared, except to keep the patient in a favorable position, so as to give as little pain as possible.

Food and water should be supplied but with care, the food being cautiously increased as the stomach becomes more obtund.

Baltimore

July 15th

digestion impures. The food should consist only of such articles as beef tea, or chicken tea. Small quantities of milk, sweetened and water in equal parts, may be given - it is better to bail the milk before using.

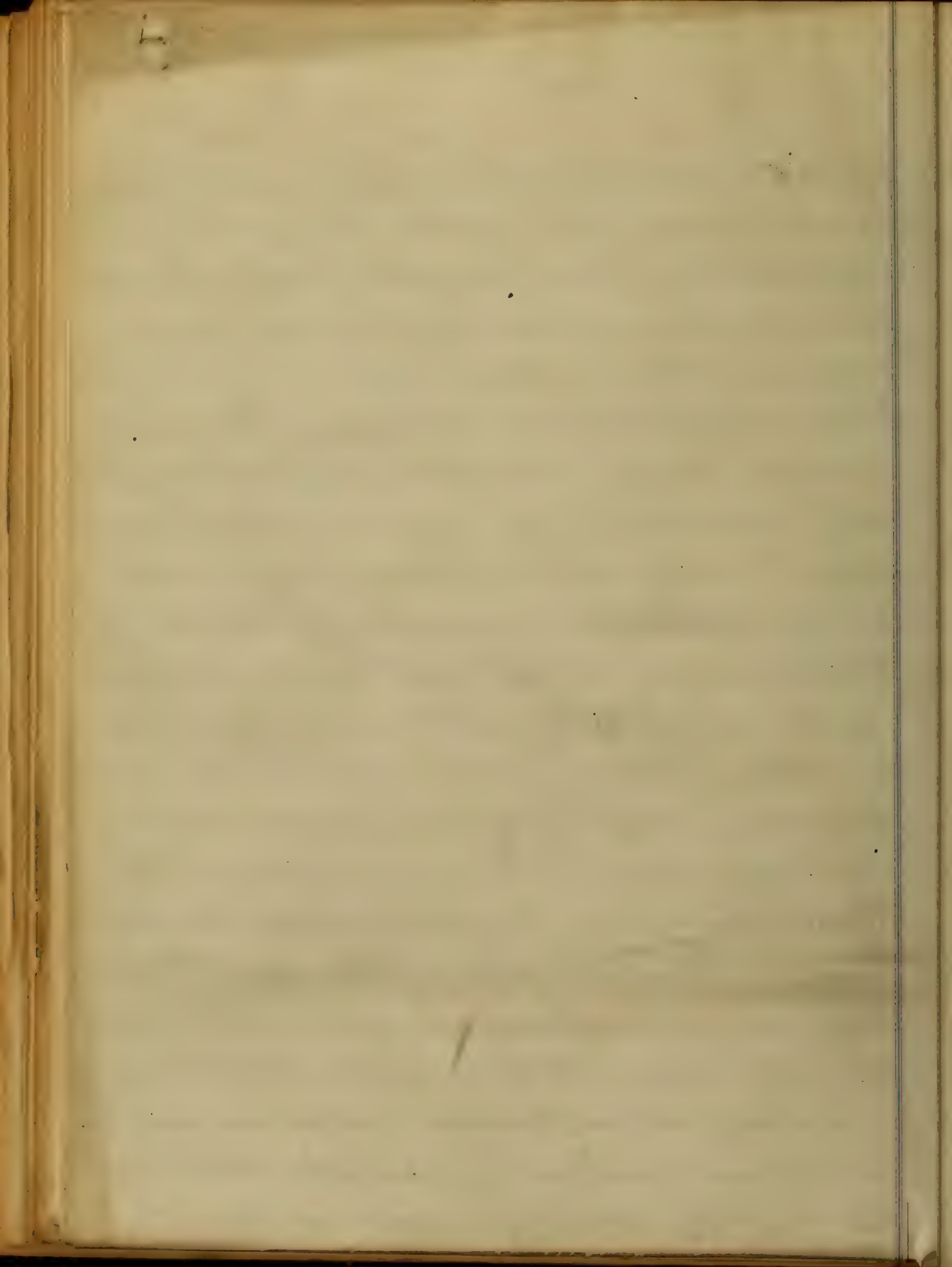
Finally, as the child's health becomes any much impure, it may be allowed such articles of food as it was formerly accustomed to, and its health and strength will probably be fully restored. Generally during such a but little medicine is required. Should fever become high, small doses of Spirits Nitrous Ether would probably be useful, in two or three drop doses every hour in water. If the urinary secretions remain thick, some of the acetate of potash may be given with the above amount of Nitrous Ether, with not much water as they stand mixed.

Reaction having been pretty well established, the child may convalesce rapidly till perfect health be regained, or in a few days the case, it may become the subject of a simple or inflammatory diarrhoea. When this is the case, the child is put in an extremely weak and languid condition, and should be treated by such remedies as are best adapted to the nature of these diseases, namely, stringent and bricks.

If the child be in the city removal to the country would be the most appropriate measure that could be taken to secure a speedy recovery.

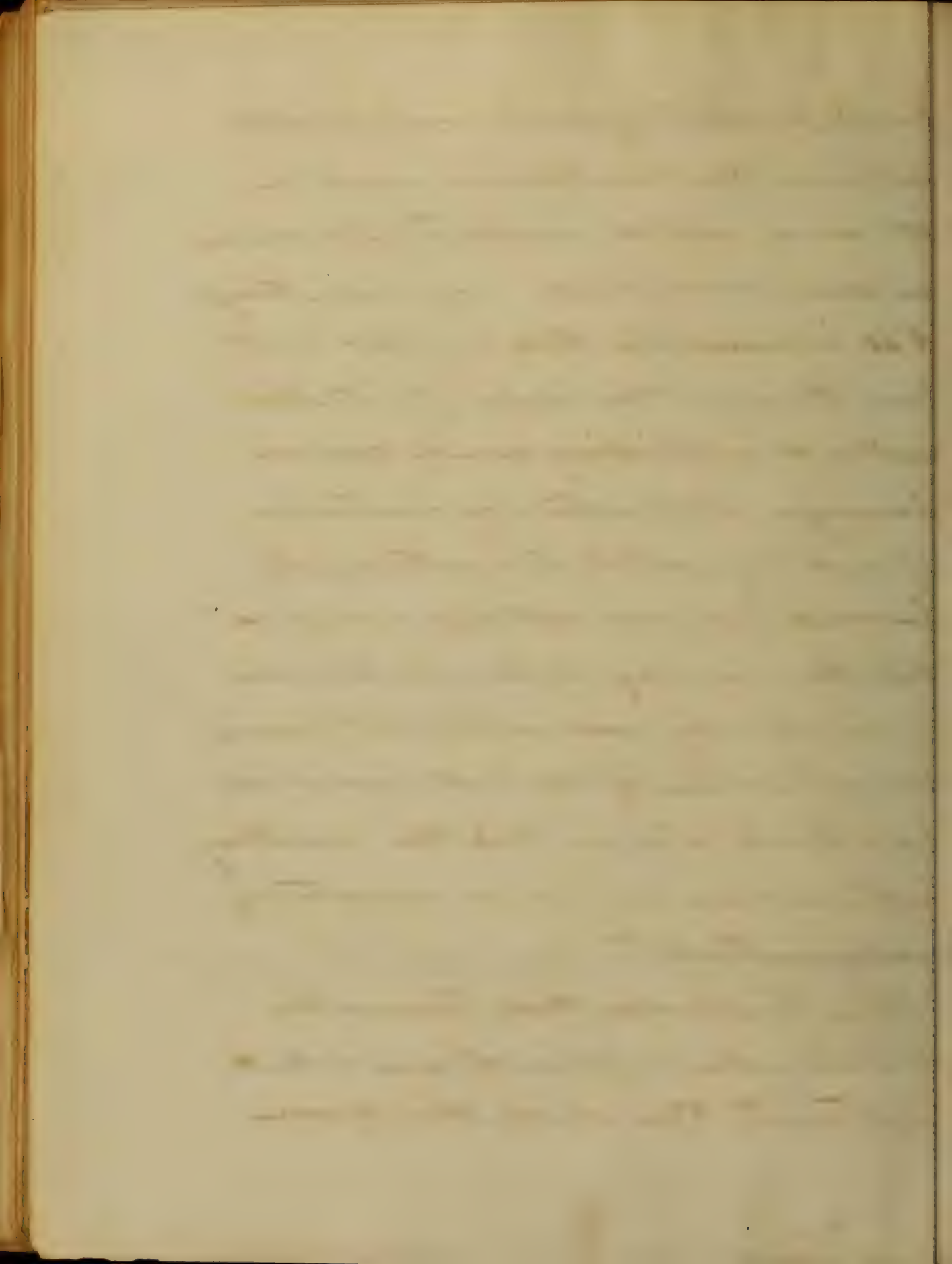
Very respectfully.

Your Obedient servant, - A. A. P. Ellis!



In all penetrating shot wounds of the abdomen the peritoneum must be to some extent involved. The viscera, in some rare cases, may escape, though it is inconceivable that a bullet could pass through the loops of intestine without inflicting some severe damage, at least by contusion, if not by actual laceration. If, however, we can satisfy ourselves that the injury to the peritoneum is an entirely uncomplicated lesion, the experience of the last few years has I think shown that the resulting inflammation can be comparatively easily controlled.

It is probable that traumatic peritonitis differs from what is termed the idiopathic form



mainly in a less liability to become
diffused. While fully recognising
the danger of spreading inflammation
from mechanical violence to the
peritoneum, it is to be remembered
that a limitation of the inflammation
by salutary adhesions more commonly
occurs. Effusions are the most
constant cause of general traumatic
peritonitis, yet this does not seem
to be a necessary result of effusions
of blood and pus, and instances are
on record where the more irritating
extravasations of faeces, bile and
urine has caused only a circum-
scribed peritonitis. The pathology
of the inflammation is analogous
to that of pleuritis and pericarditis
(Kiemeyer, Kindfleisch); there is

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hyperaemia, a proliferation of the epithelium, and a migration of the white corpuscles in great numbers, leading to the formation of young connective tissue and giving the membrane a velvety appearance. The surface is then covered by a fibrinous exudation containing young cells and there follow sero-fibrinous exudations in great variety. The diffusion of the inflammation, unless in case of effusion of some irritating fluid, must take place before the stage of serous exudation as it is promoted mainly by the movements of the opposing surfaces on one another.

The inflammation usually begins with severe pain at the seat of

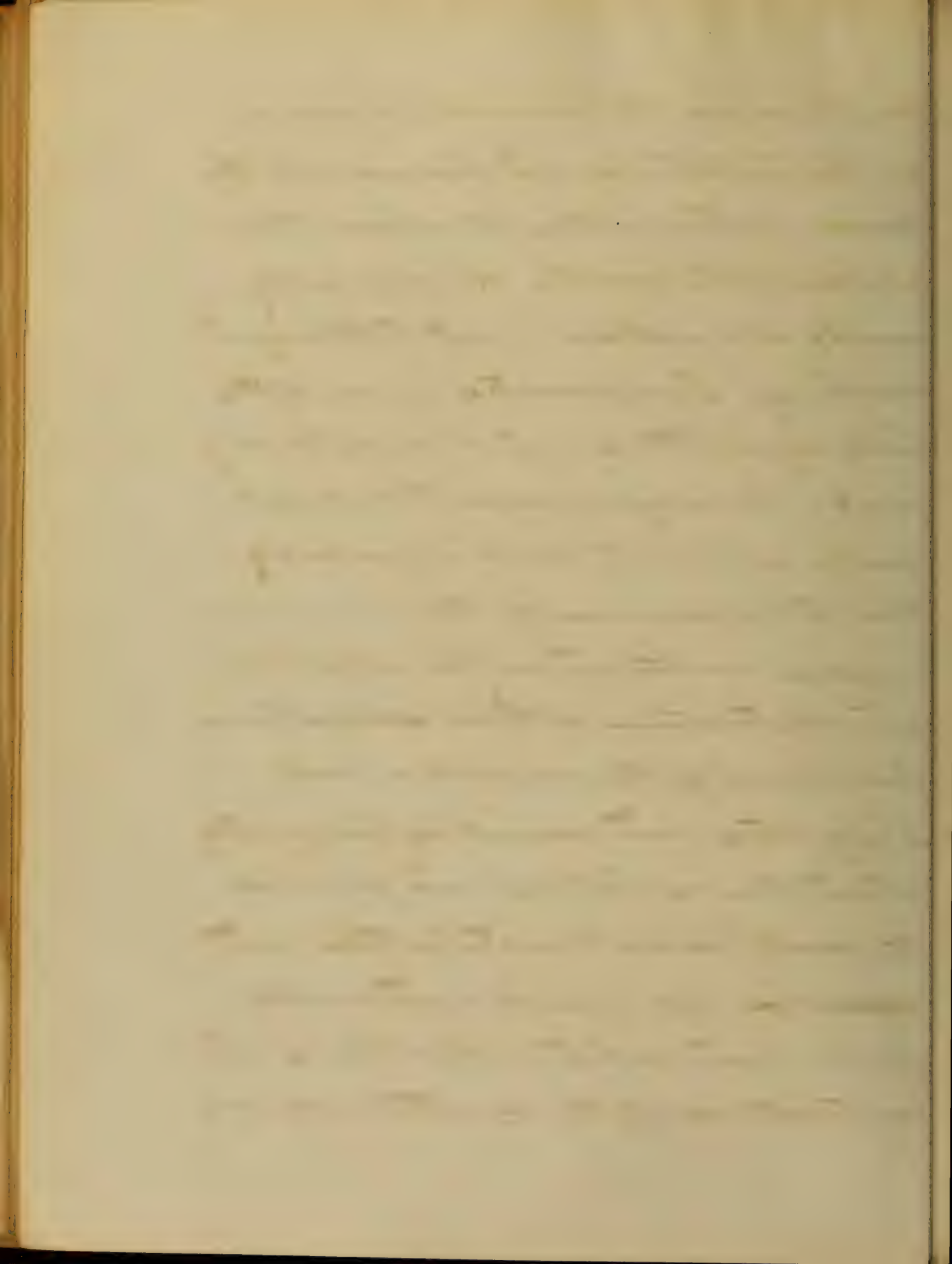
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injury, and, if there be effusion, spreads rapidly over the whole abdomen. But if propagated from a wounded viscus its progress is slower, and the pain which was before limited to the seat of injury gradually increases and extends. There is in all cases general depression. Fever is always a prominent symptom and the temperature has generally been found to rise to 105° or more; but the commencement is not marked by a severe chill followed by febrile reaction as in peritonitis from idiopathic causes. Pain is the most constant and characteristic symptom, and it is increased by the slightest pressure. The patient fixes the

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diaphragm to prevent pressure
on the intestines and draw up the
lower extremities to relax the
abdominal walls. He carefully
avoids all motion, loud talking and
coughing. Tympanitis is one of the
early symptoms and it is often very
great. Niemeyer says this is not
easily explained but is probably
due to expansion of the
gases contained in the intestine
and obstruction to their escape from
paralysis of the muscular coat.

Eructus and vomiting frequently
attend this condition and give rise
to great pain. Constipation and
dysuria, frequent and weak
pulse, and rapid alterations and
contractions of the countenance are



The most prominent remaining symptoms. The mind is usually clear; but at the approach of death the patient sometimes becomes apathetic and delirious. The pulse then becomes more frequent and throody, the countenance greatly altered, and the whole surface of the skin is bathed in a cold clammy sweat.

The disease may be fatal in a few hours; but the fatal termination usually takes place from the third to the fifth day. In those cases that recover convalescence is generally very slow, and visceral adhesions are apt to take place which may subsequently cause much pain, and even a liability to a relapse.

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Wounds of the Stomach.

Dr Otis, in "The Medical and Surgical History of the War of the Rebellion", remarks that a point from ocular demonstration or the introduction of the educated finger, ^{of the contents of the stomach} extravasation, is the only pathognomonic sign of a rupture of its walls. The great variations in the position of the stomach in the abdominal cavity, and of its relations with surrounding parts in different stages of repletion or emptiness, render the certain diagnosis of wounds of this organ very difficult. The point of entrance, depth and direction of the wound when the state of the stomach is known; the escape of food or drink, vomiting

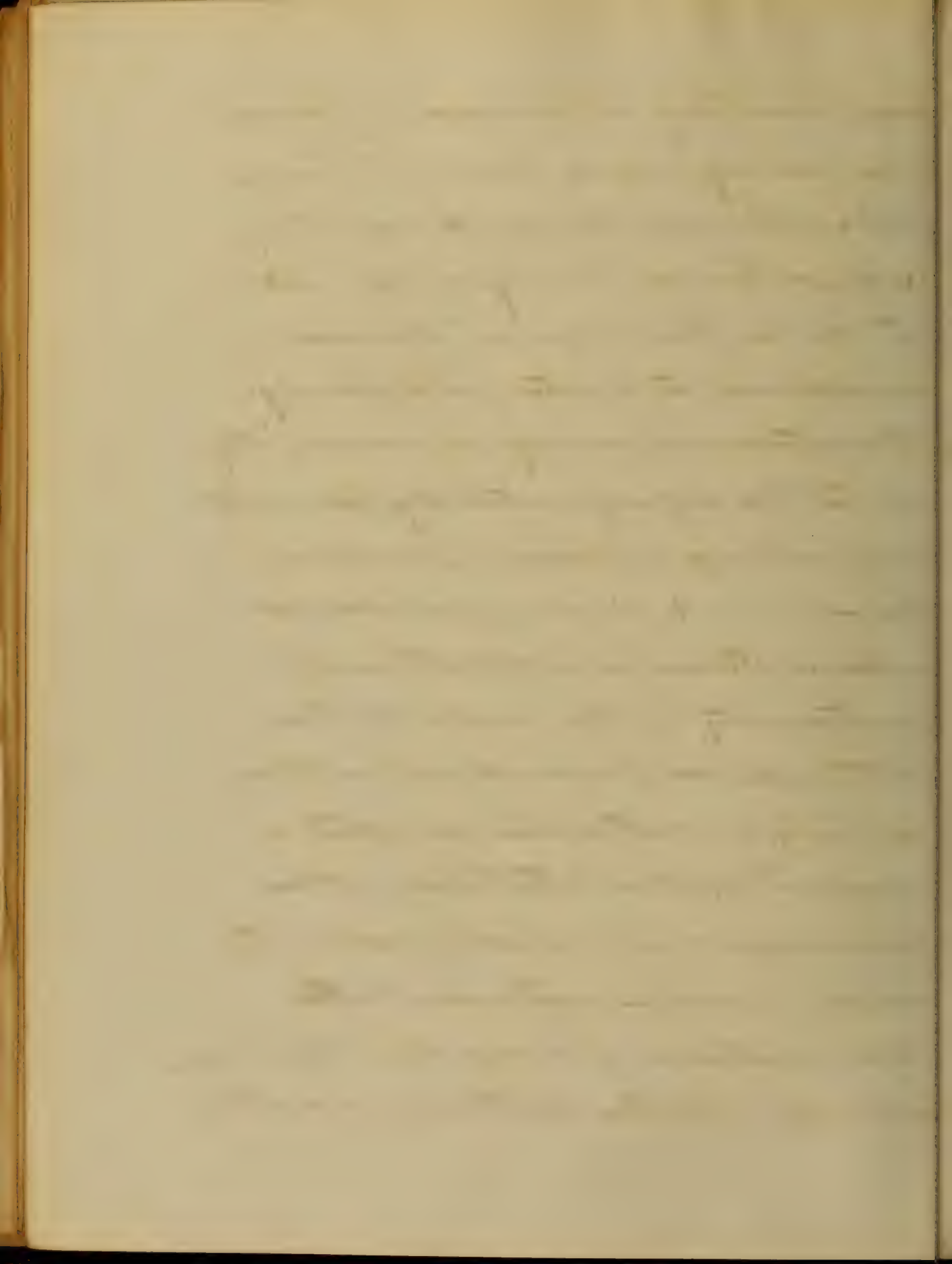
of blood, faintness and pain over the seat of injury are the principle signs. In addition there may be thirst, singultus, sudden meteorism, small and frequent pulse with cold extremities, pallor and other symptoms common to rupture of other parts of the alimentary canal.

The danger of extravasation depends of course on the size of the wound and the amount of food in the stomach at the time the injury is received. It is said not to have occurred in some cases when the stomach was known to be partially filled, but this could happen only when the wound is small and the organ totally paralyzed for a sufficient length of time for

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inflammatory adhesions to form.
In many cases these adhesions
take place with great rapidity,
a few hours being sufficient
to cause the opposed serous
surfaces to unite quite firmly.
Hæmatemesis coming on immediately
after the injury certainly presents
very strong evidence of such a
lesion; but it may be absent
when there is a solution of
continuity of the walls of the
stomach, or present when there
is only a contusion, or after a
wound of the intestine. The
hæmorrhage may be so great as to
cause syncope and even death.

The question of surgical interference
in case of rupture of the walls of the



stomach has been much discussed.

The conclusion arrived at by all the best authorities seems to be that when there is no doubt ^{of the nature} of the lesion and extravasation has taken place it is proper to enlarge the opening in the abdominal parietes, clear out all foreign matters and stitch up the wound. The method of doing this does not differ from that used in wounds of the small intestine and will be spoken of below. Fistulae may be a sequense of shot wounds of the stomach, but there are only two well authenticated cases of recovery with fistulae on record. In the case of the famous Alexis St. Martin, who was still living in 1873, the remained open; in the

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other case, which is recorded by
Baron Percy in 1794, it gradually
contracted and finally closed. The
records of the late war furnish
three cases of ^{secondary} gastric fistulae in
all of which the patients died in from
three to twelve weeks after the fistulae
became complete, but they were all
complicated by other serious injuries.
Shot wounds of the stomach
are generally complicated with
injuries to the vesica with which
it is in relation and this of course
adds greatly to the mortality. In
uncomplicated cases, however, the
mortality is very great, perhaps
next to wounds of the small
intestine. Percy places it at 75-
per cent, but Dr. Stie after a rigid

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analysis of all recorded cases
estimates that it is never more than
seven per cent. than seventy-five.
In the uncomplicated case I
have recorded above, I feel certain
that the boy's recovery was entirely
due to the fact that the stomach
was empty at the time he was
injured, and that he was not
allowed to take any food until it
was pretty certain the wounds had
been closed by inflammatory exudation.
The ball passed through at some
distance from the pyloric extremity
and no large vessels being wounded
the hemorrhage was inconsiderable.

Wounds of the Small Intestine.

Wounds of this portion of the

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alimentary canal are the most fatal of all wounds of the abdomen; not because the visceral lesion is in itself destructive, for these wounds may be closed with great rapidity, but because the conditions necessary to prevent the entrance of foreign matters into the peritoneum are so rarely fulfilled. Shot wounds of the small intestines are frequently multiple on account of the convolutions; there may be single or twice perforations and the calibre of the gut may be partly or wholly divided. When it is entirely divided the extremities are drawn apart and puckered and it is impossible to distinguish the upper from the lower end

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except by the escape of faecal matter. Small perforations, not exceeding four lines in diameter may be closed by the contraction of the longitudinal and circular fibres and by the eversion of the mucous lining. With regard to the relative frequency of wounds of the three divisions of the intestine the ileum from its more exposed situation stands first and the jejunum next, while but few cases of wounds of the duodenum have ever been observed. Shot injuries of this latter portion of the intestine are most commonly associated with mortal lesions of the adjacent parts. The descending and middle portions being loosely fixed between the laminae of the meso-colon without

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any proper peritoneal coat it is possible for it to be wounded with out extravasation of its contents into the great peritoneal cavity.

In wounds of the jejunum, if received in the condition its name implies, the danger of extravasation is not immediate; but even if received during fasting entozoa may intrude into the peritoneal cavity. Lesions of the large blood vessels of the mesentery and of the other large vessels of the abdomen are complications of not infrequent occurrence.

The wounds of the ileum can in no way be distinguished from those of the jejunum except by actual examination of

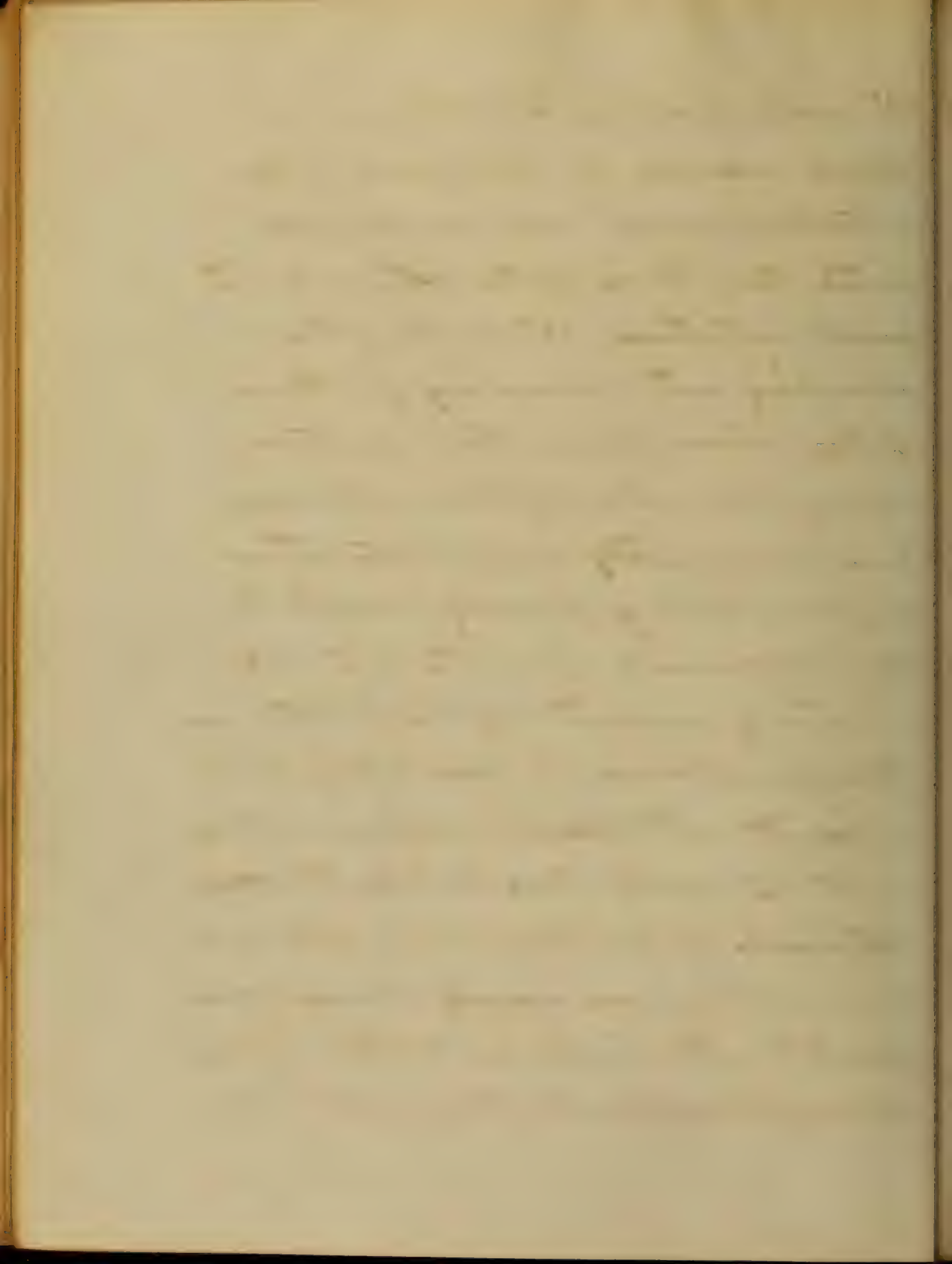
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The gut. Injury to the large blood vessels is the most frequent complication, and extravasation of fecal matters is more likely to take place in the lower part of the canal. There are no symptoms pathognomonic of wounds of the small intestine. Sudden meteorism, from the escape of the intestinal gases is apt to be developed and the symptoms of shock are likely to be very pronounced; but many cases occur in which neither symptom is very prominent. Vomiting and bloody stools will very generally follow and peritonitis may be suddenly developed by the escape of acid substances from the intestine.

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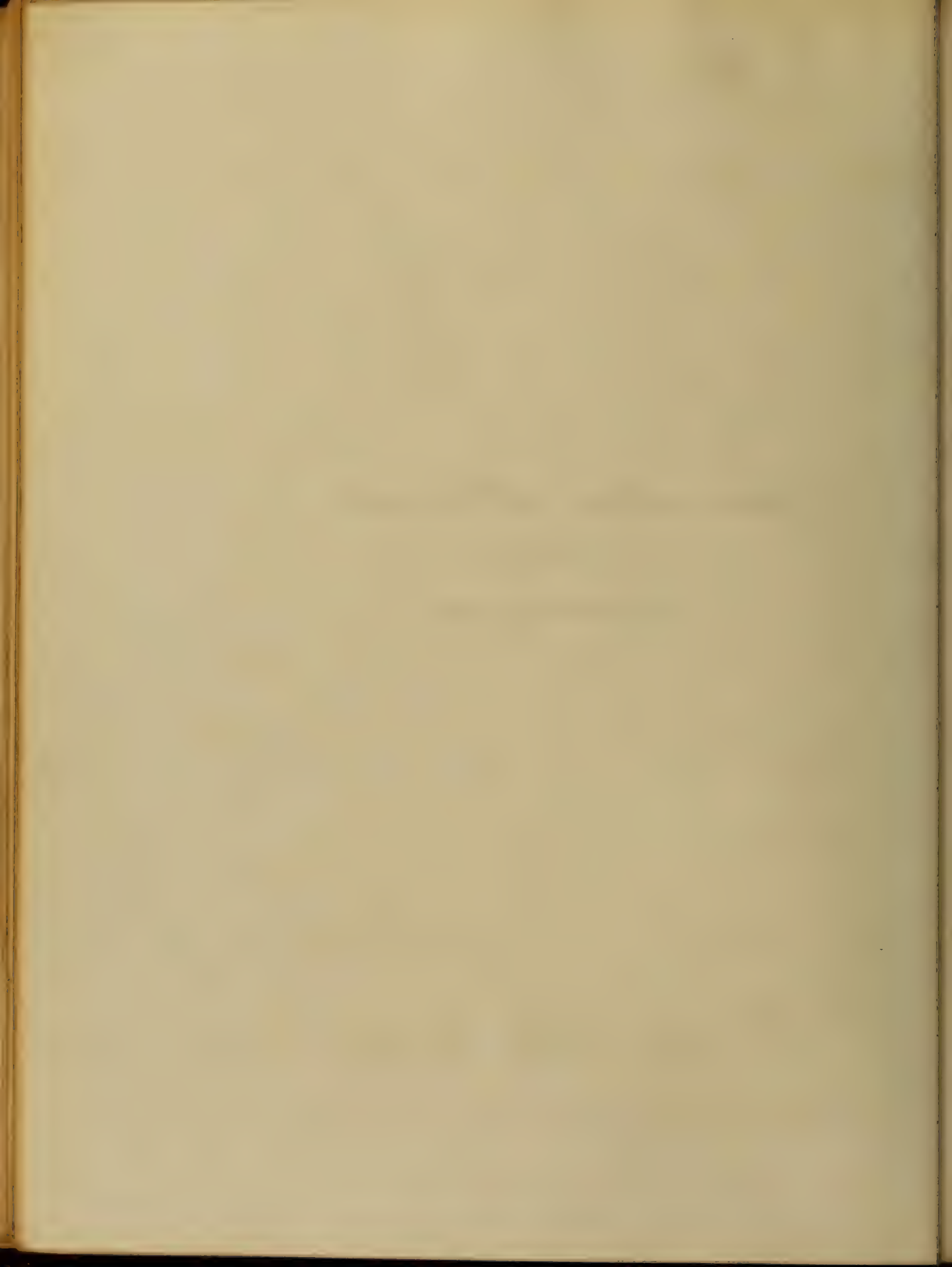
Wounds of Large Intestine.

Shot wounds of this part of the intestinal canal are much less fatal than those of the stomach and small intestine. Wounds of the ascending and descending portions of the colon, from their position along the sides of the abdomen, less frequently implicate other organs. Being firmly bound to the abdominal parietes and but partially covered by the peritoneum this membrane is less likely to be injured, and fœcal extravasations into its cavity less liable to occur. Wounds of the transverse colon, on the contrary, are nearly always complicated with injuries to other organs, always implicate the peritoneum.



Gun shot Wounds
of the
Abdomen.

Claud Van Bibber



Case. I. On Sept. 17th 1845: Thomas Campbell a boy of about twelve years of age was accidentally shot by his brother. The next day Dr. Char. O'Donovan, the attending physician, being obliged to leave town, asked me to see him. I got the following history of the case: About seven o'clock in the morning the boy found an old pistol in the store and took it up stairs to his brother. Not knowing it was loaded this young man covered it with a cap, and being at about ten feet distance, fired the pistol at his brother, the ball striking him while ^{he was} in a stooping position. The ball which was over one third of an inch in diameter

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entered the back on the left side just below the border of the last rib one and three quarter inches from the line of the spinous processes, and made its exit one half an inch to the right of the median line and ~~two~~ two and a half inches below the tip of the xiphoid cartilage. A short time after the accident he vomited about four ounces of blood and during the morning vomited three or four times more, throwing up about a tablespoonful ^{of blood}, each time. He passed his urine without pain and there was no appearance of blood. He was not allowed to take anything but small pieces of cracked ice on the 17th and 18th, and was ordered one drop Peajindis Sol. Morph.

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every hour. When I saw him in the evening of the 18th he was much depressed, with a hot & dry skin, and pulse 110 and very weak. There was great tenderness over both wounds. On the 19th he was given a teaspoonful of cocaine every hour. Was much worried during the day by hammering next door and in the evening his temperature was 102.8° and pulse 120. There was great tenderness over epigastric and umbilical regions, tympanites, tension of abdominal muscles and anxiety of countenance, in fact every symptom of peritonitis. Ordered two drops of Majumdar's Sol. pro re nata and cloths wet with cold water to be laid over the stomach. Next day condition about the same. Pulse 128,

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temperature not taken. Had some difficulty in passing urine on account of pain. Examination by the microscope showed a good many blood corpuscles and some disintegrated renal epithelium. During the next two days his condition remained about the same. He was kept fully under the influence of morphia, and allowed about a teaspoonful of cream a day. On the 23rd all the symptoms were much improved, and he had a natural evacuation from the bowels. The wound in front had healed; - the one on the back was sloughing and two inches in diameter. It was washed out with a sol. of Carbolic acid. - 24th inst. His notions were increased to half a pint of cream a day, and on

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The next day he was given beef tea.
It made him vomit but did not
give rise to any other bad symptoms.
The blood had disappeared from his
urine on the 25th inst. From this
time he continued to improve.
He was kept perfectly quiet and not
allowed over a pint of cream during
the twenty four hours for another
week. A piece of cloth was
removed from the wound in the
back and it then healed rapidly. At
the end of a month he had sufficiently
recovered from his long starvation to
resume his employment.

The diagnosis in the case was, a
perforation of the walls of the
stomach and contusion of the left
kidney.

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The above case was one of the first which came under my observation as a medical student, and by far the most interesting that it has been my fortune to watch throughout a critical course. It is for this reason that I have selected this class of lesions ~~as~~ a text, although the subject may seem to be one not altogether suitable for one who lacks the wisdom of observation and long experience. For I think that in writing a thesis for a medical examination the student should choose some subject with which he is practically familiar. He is more apt to take an especial interest in any disease that has been studied

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with a view of making immediate use of his knowledge; and that knowledge is better retained after seeing theories reduced to practice.

I propose to speak of shot wounds of the abdominal cavity or uncomplicated by injuries to the cavities adjacent to it; viz. the thorax, the pelvis and the spinal canal. The abdomen there is bounded above by the diaphragm; below by a plane passed through the iliopectineal line, or superior strait of the pelvis; posteriorly by the lumbar vertebrae; anteriorly by muscles; and laterally by muscles and ^{the} inferior ribs. This will include nearly all the viscera covered in whole or in part by the peritoneum; viz. the stomach, small and large

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intestines, liver, spleen, pancreas,
and kidneys, and the large vessels.

This class of injuries are interest-
ing on account of the immediate
connection of all the parts involved
with the most important functions
of the economy; the intense form
of inflammation which almost
invariably follows them, and
the wide field that is open for
improvement in the treatment
of wounds of the several viscera.
John Bell in his "Discourses on
the nature and cure of wounds"
uses these words in speaking
of wounds of the belly: Every
wound is a disease, and every
disease is different according to
the nature of the part affected,

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and according to the office which
the parts are destined to fulfil.
In the abdomen we find the
principles which explain its
diseases very simple and plain;
we find the chief cause of danger
to be the tendency of the peritonum
to inflame; we find every wound
apt to excite this inflammation,
and every inflammation, however
slight, apt to spread, to extend
itself over all the viscera, and
terminate in gangrene and death.
Upon these grounds we cannot
but pronounce a wound of the
belly to be a mortal wound."

The principles here laid down still
guide us in the treatment of these
wounds. The lesions of the several

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viscera will produce symptoms peculiar to the disorders of their respective functions, and these must be treated according to the nature of the wounded part. There will arise many complications, for the abdomen contains more parts of very dissimilar uses than any other cavity of the body, but still the main danger to be guarded against is inflammation of the peritoneum. The result of observations of these wounds during the numerous wars of the last three quarters of a century has not added very greatly to our knowledge on this subject. But still the large experience acquired has given more precise ideas as to the relative frequency and death rate of these injuries, and

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put us in possession of numerous clinical observations and post-mortem descriptions of the effects of lesions of the different viscera, which fail to teach us more fully the phenomena distinctive of such injuries because of our imperfect knowledge of the normal physiological functions of many of the organs involved. However, this mass of observations affords some clues for differential diagnosis, and hints as to what had better be left undone, if it does not teach us what to do. The experience of so many years leaves unchanged the facts that in shot wounds of the abdomen the prognosis is most unfavorable, the diagnosis very obscure, and the results of treatment discouraging.

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contains a list of names and
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The addresses are written
below the names and are
also in a cursive hand.

and one very fatal. The wounds of the ascending and descending portions are very generally followed by temporary and sometimes by permanent stercoval fistulae.

There is nothing by which wounds of the large intestine can be distinguished from lesions of other organs, except the position of the wound, and the escape of faecal matter externally. -

In ^{shot} wounds of the small intestine the common practice has been to seek to avert extravasation into the peritoneal cavity by arresting peristaltic action by opium, and enjoining absolute quiet, and to indulge in the hope that adhesions may form through

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the efforts of nature. Experience teaches us such hopes are illusory. Extravasation takes place in the very large majority of instances, hyperaemic peritonitis ensues, and generally proves fatal in forty-eight hours. The pathological evidence of recoveries from wounds of the small intestine by the unaided effort of nature, even by the establishment of a preternatural aneurism, is limited to a very few instances. The cases of successful suture of the intestine, on the other hand, are very few in number, but still the success obtained. I think warrants us in saying that in wounds of this viscus, where there is danger of extravasation

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The proper course to be pursued is to enlarge the external wound and close that of the intestine by suture. Wounds of the large intestine will often so well without interference, yet there are exceptional cases in which extending the external wound and sewing up the wound in the colon is the best and only means of preventing extravasation.

Prof. Gross, whose authority is greater, while heartily endorsing the propriety of exploratory incisions and of enterostomy in cases of ordinary intestinal wounds without protrusion, regards such measures as unlikely to be of benefit

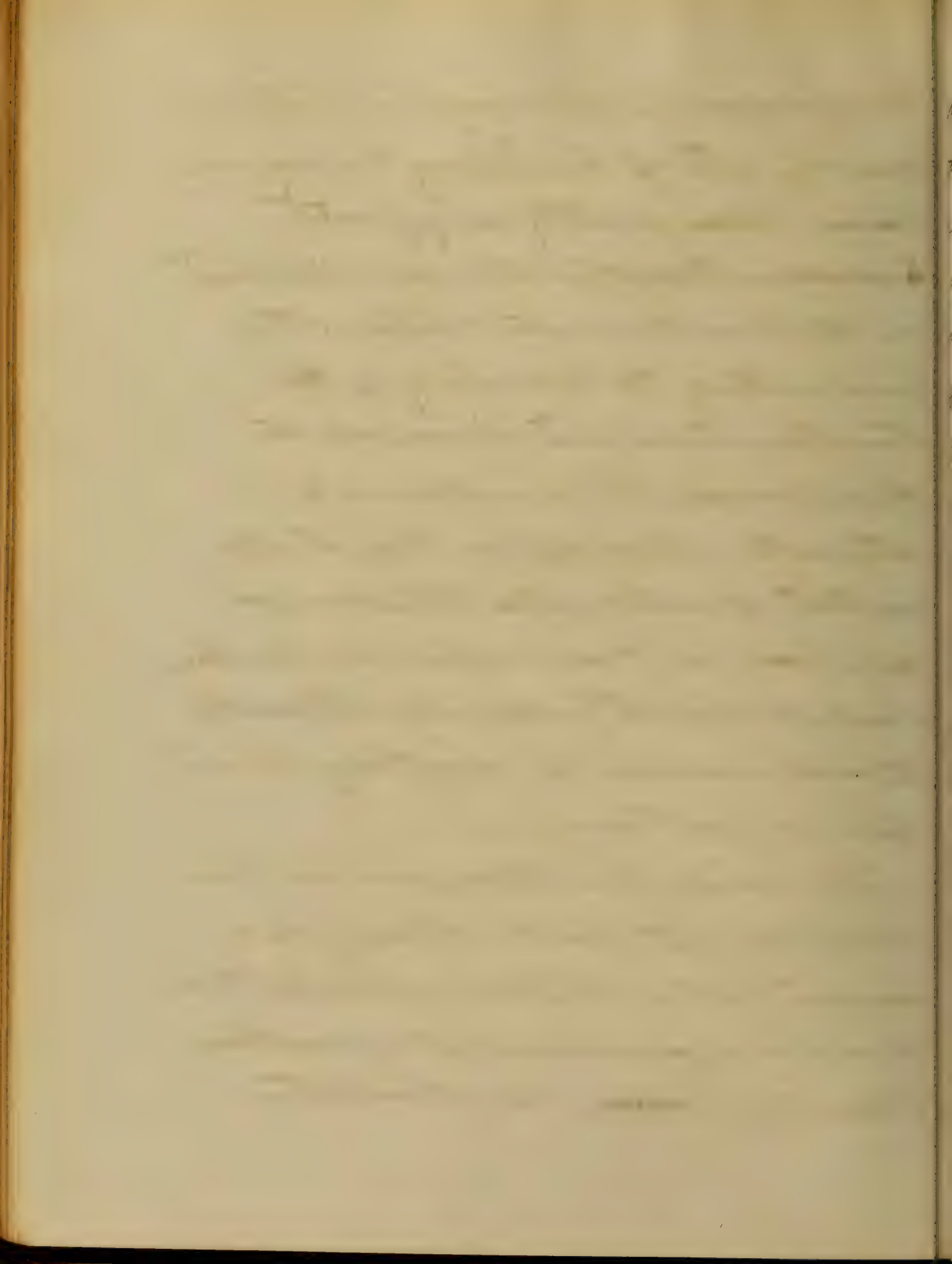
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because such lesions are commonly multiple. This consideration is undoubtedly of great weight in prognosis; as to treatment, it may be urged that, in proportion as the danger of faecal extravasation is multiplied, the necessity of employing the only effective remedy becomes more imperious. It is a surgical axiom that no operation should be undertaken which will endanger the life of the patient; but in these desperate cases if we do not succeed in closing all the openings in the intestine the death of the patient is certain and we have done no harm. The results of operations for ovariotomy demonstrate that

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The dangers of opening the peritoneal cavity and of handling the viscera have been greatly exaggerated. Success in these operations will depend on attention to minute details, to the preventing the lowering of the temperature and above all to cleanliness. It is impossible to estimate what effect Prof. Lister's method of antiseptic treatment may have on these difficult operations, but it should certainly add greatly to our success if everything claimed for it be true.

The variety of methods which have been devised for the closing of a wound of the intestine indicate that it is a very successful operation. Those that have best stood the



test of experience all have for their object the inversion of the edges of the wound and the close approximation of the edges covering in such manner as to favor its quick union by inflammatory exudation, and to prevent the escape of anything from the wound. The method of Lembert, or Gely's modification of it, are probably the best sutures that can be used. Of late years the continuous suture, which had long fallen into disuse, has become popular again and bids fair to be as successful as any other if applied with proper care and precautions.

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Wounds of the Liver.

The records of the late civil war show that shot wounds of the liver are not nearly so fatal as has been heretofore supposed.

If the patient escape the early danger of hemorrhage, they are likely to die of traumatic peritonitis, from the escape of bile, or from abscess of the hepatic parenchyma. General inflammation of the substance of the liver is not likely to follow. The complications generally accompanying the wound are fractures of the ribs and wounds of the stomach & lungs intestine.

Wounds of the Spleen.

This organ is less liable to be

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wounded than the liver, because of its smaller size and deeper situation. Fatal hemorrhage may take place from shot wounds of this viscus but numerous pathological preparations show that it may be wounded without giving rise to any great of hemorrhage or inflammation. Alterations of texture are limited to the immediate vicinity of the solution of continuity, and there is but little tendency to the formation of pus unless foreign matter are confined. Of the physiological effects of extensive lesions of this organ, and of the Pancreas, nothing is known. It is much to be regretted that in a case of extirpation of the

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entire spleen for a shot injury,
recorded during the war, the patient
was not kept under observation.
Wounds of the kidney.

Wounds of the kidney are indicated
by the depth and direction of the
wound, pain in the renal region,
haematuria and spasmodic retraction
of the testes. If the wound extend
to the peritoneum urine may be
extravasated into its cavity and
cause fatal peritonitis. Urine
may also be extravasated into
the lumbar connective tissue,
and it will then be proper to
enlarge the opening in such manner
as to prevent infiltration into
surrounding parts. The possibility
of formation of large coagula of

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blood in the bladder should be remembered, and a large catheter and vesical injections should be used only if indicated.

The differential diagnosis of wounds of the abdomen is very unsatisfactory. The numerous examples of unsuspected lesions revealed after death show that there is no distinctive sign of wounds of either of the abdominal viscera save the escape externally of its secretions or its contents.

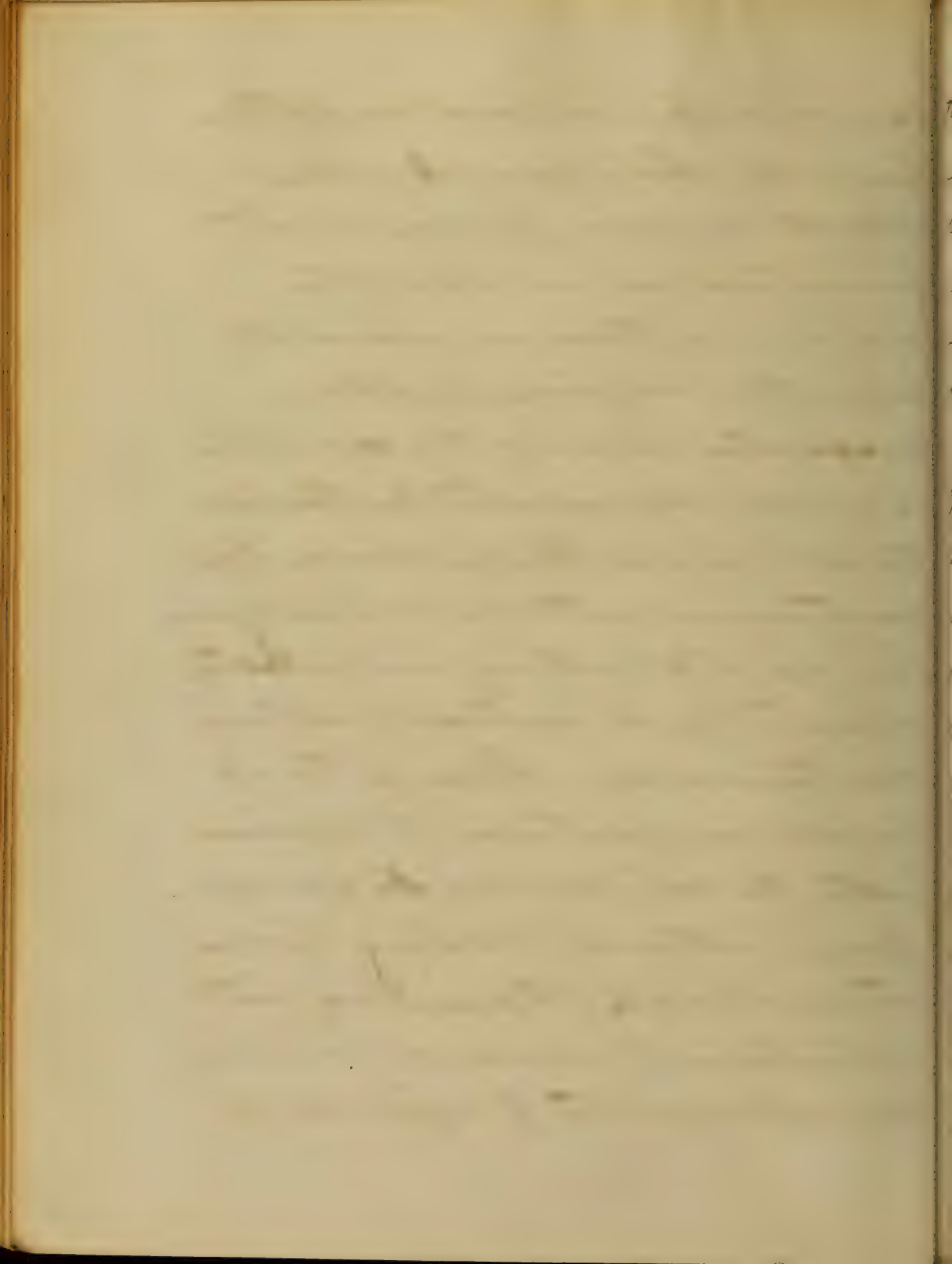
Post-mortem examinations show the uncertainty of haematemesis and bloody stools as signs of wounds of the alimentary canal, and indicate the importance of sudden necrosis

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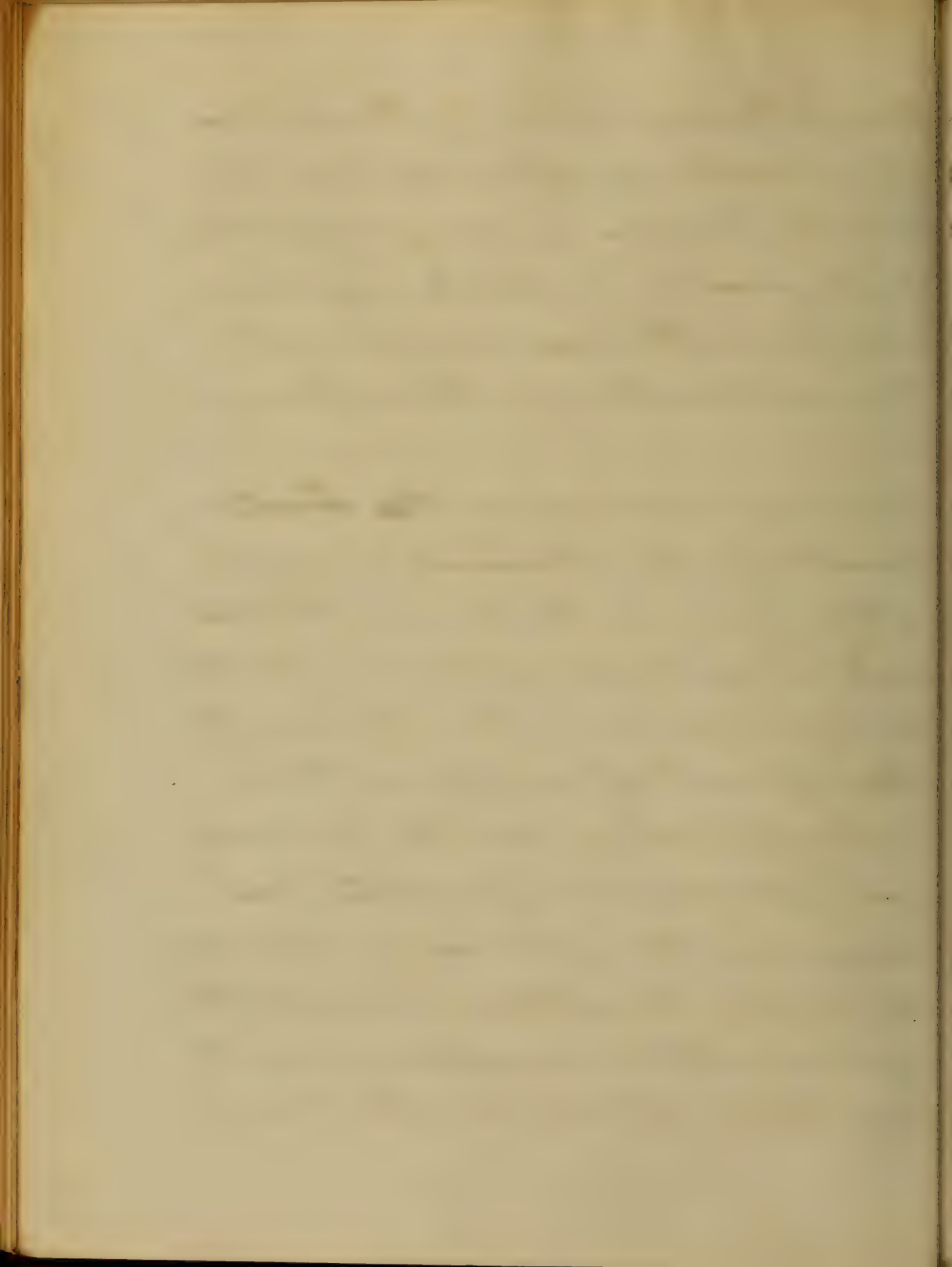
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as a sign of perforation of the
bowels. As a general rule
shock is more profound and
persistent in wounds of the
abdomen than in wounds of
any other region; but the
diagnostic value of this symptom
is greatly diminished by the fact
that it frequently follows slight
contusions without serious organic
lesion, and nothing can be deter-
mined by its intensity or long
continuance. It is of the ut-
most importance to discrim-
inate the collapse due to syncope
from internal bleeding from
trauma shock. Vomiting and
retention of urine are common
accompaniments of injuries of

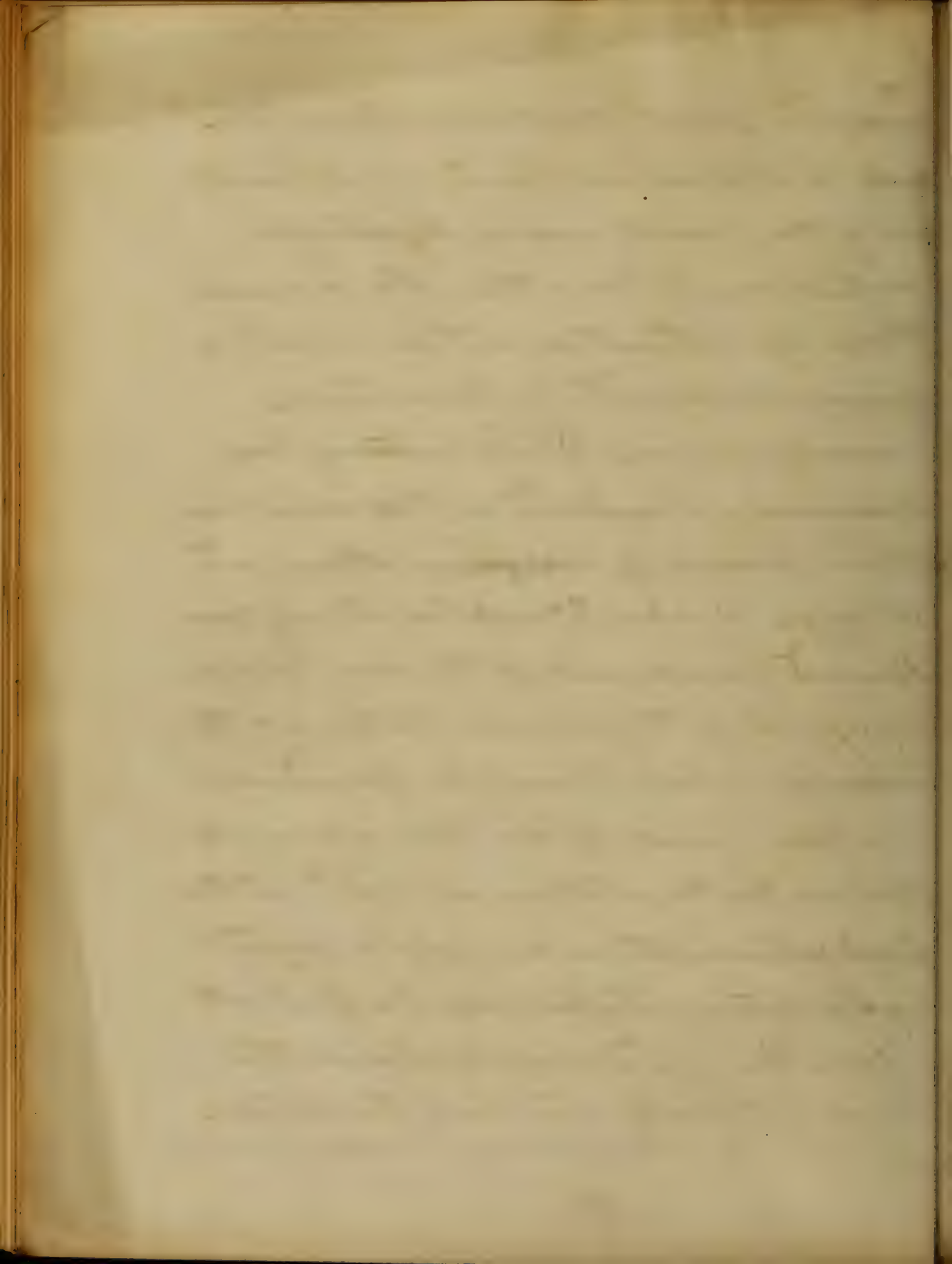


the abdomen, but by themselves
are of little significance. Persistent
localized pain is very suggestive,
but gross visceral injuries
are sometimes accompanied
by comparatively little suffering.

The main resource in the treat-
ment of all abdominal injuries
is the free use of opium. Absolute
rest and quiet are necessary to control
hemorrhage as well as to prevent
the spread of inflammation.
Cold applications over the abdomen
are most useful adjuncts. For
wounds of the solid viscera, especially
the kidney, the internal administration
of haemostatic remedies are frequently
indicated. When the intestines are



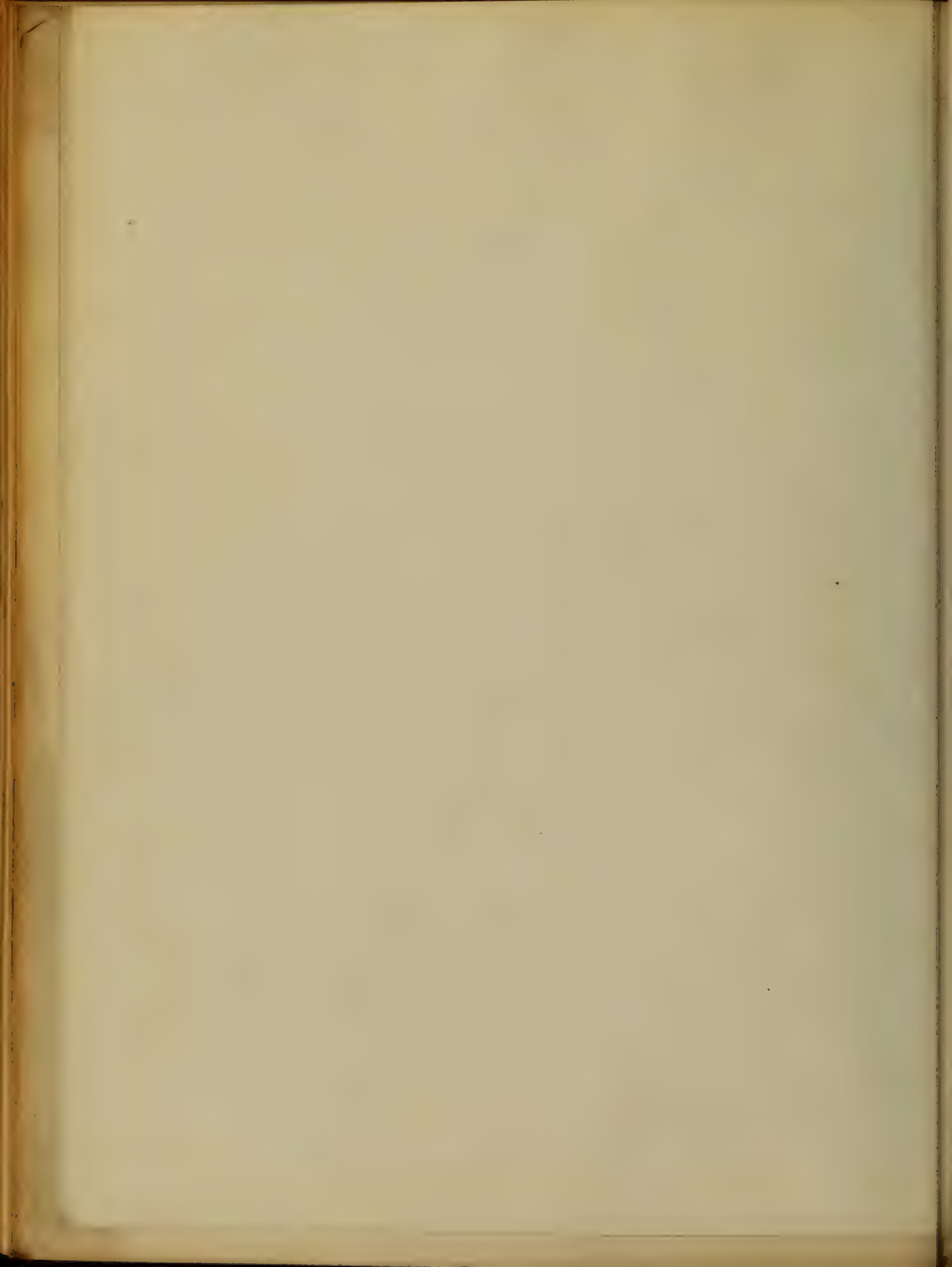
injured great care should be taken
not to allow any food, or at least
only the most easily digestible
articles, to be eaten. The administra-
tion of cathartics in these cases has
been followed by disastrous
consequences. Phlebotomy has
been usually abandoned in this as in most
other forms of disphlegmation, and
though it should not be entirely con-
demned, on account of the very depress-
ing effect of the general treatment, the
cases in which it will be found useful
are very few. When there is reason to
believe that the intestines are divided and that
faecal extravasation can only be averted
by a penitine interference, it is proper to
enlarge the wound, carefully cleanse the
penitine cavity and unite the solutions
of continuity in the wounded viscera by sutures.



Thesis
On
Topography of the Coast
Submitted to the Examination
Of the
Provosts, Regents and Faculty
Of Physic, Of the
University of Maryland,
For the degree
Of
Doctor of Medicine,
By
J. A. Irwin
Of

Charlotte,
North Carolina.

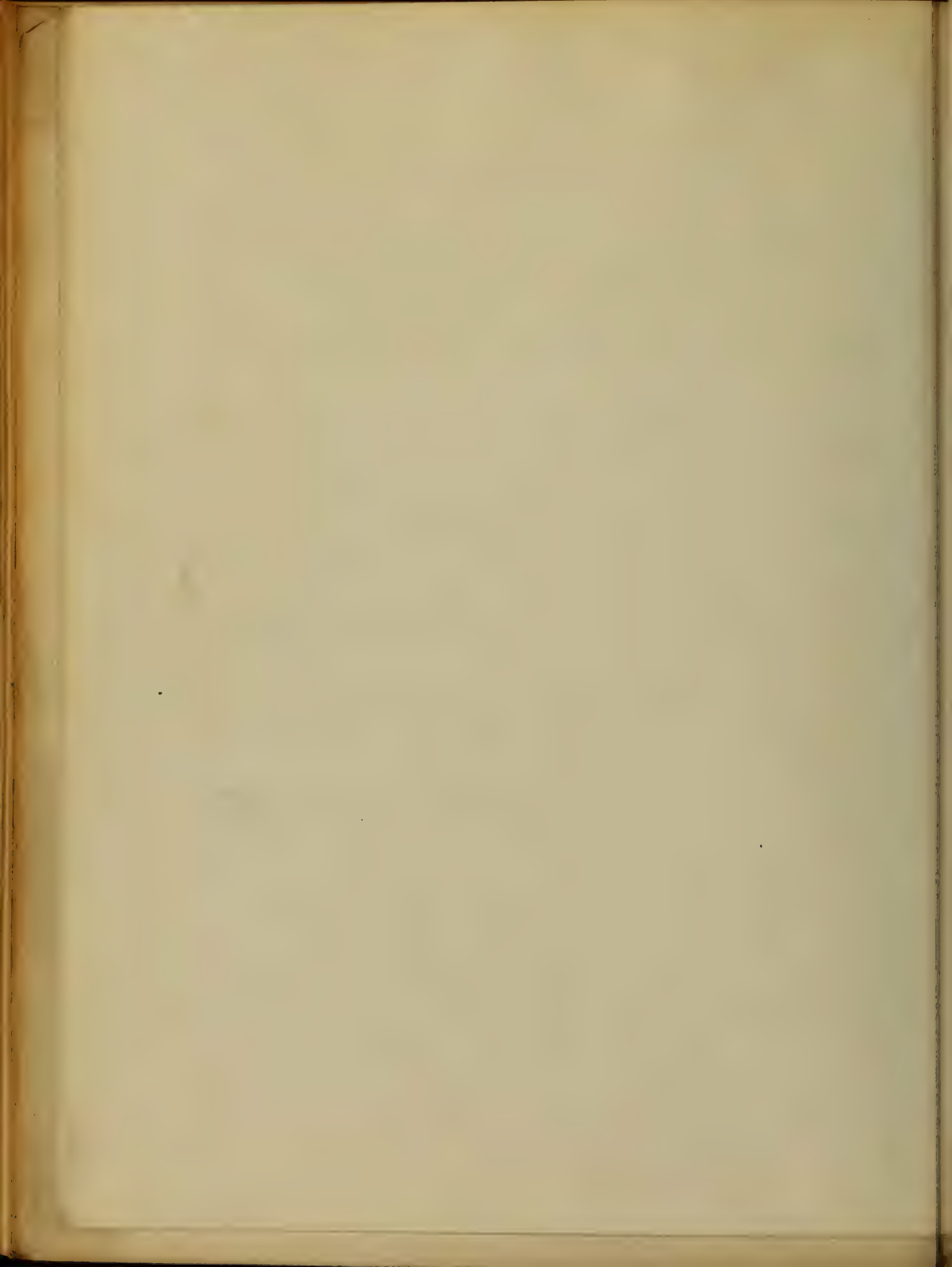
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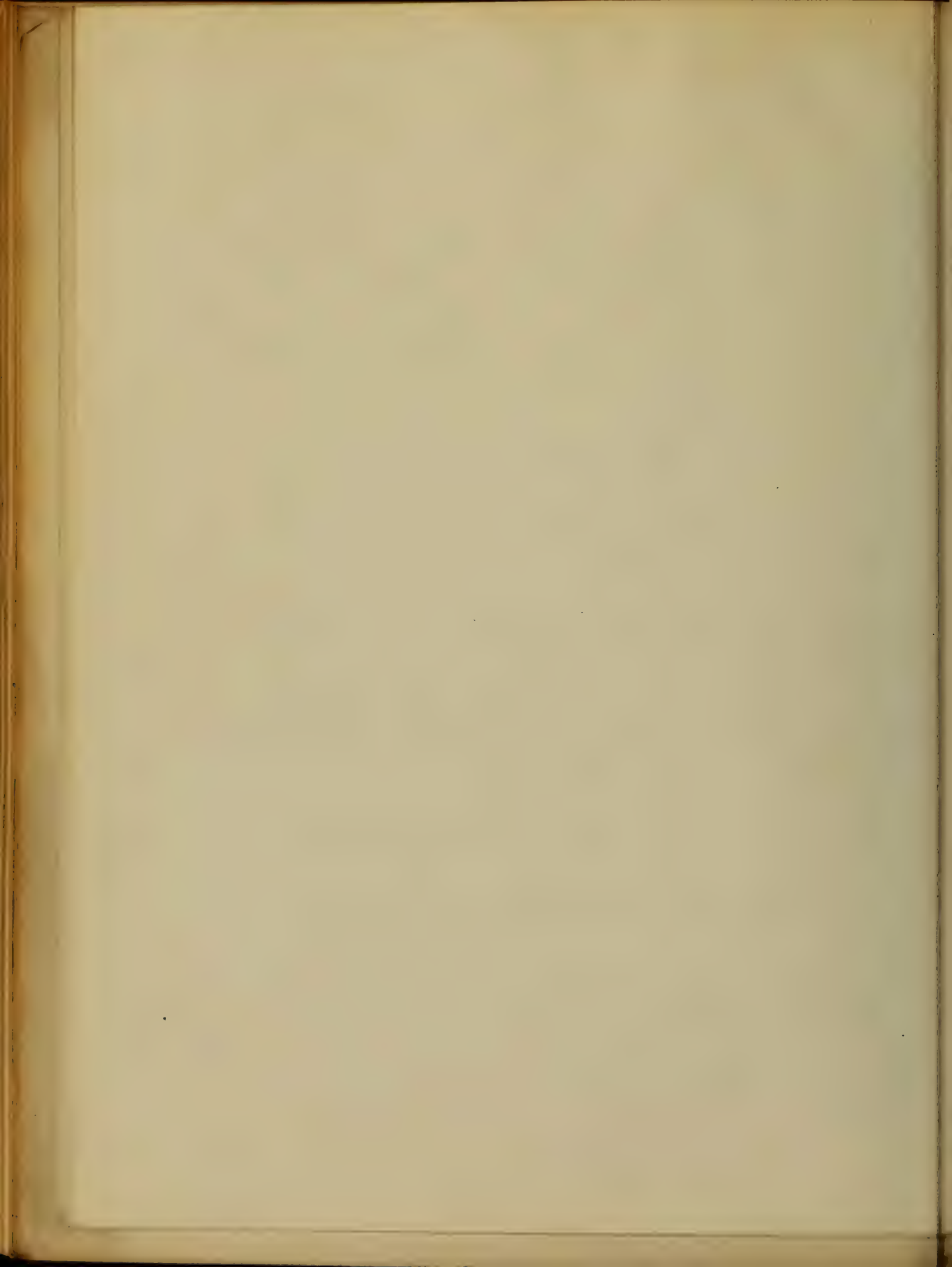
Histology of the heart.

This hollow, muscular organ, with its chambers and their valved outlets, its contractile walls and their strength and thickness, so admirably adjusted, that the healthy balance of the circulation is continually maintained, under every varying outward influence and inward emotion, is enclosed in its pericardial sac and located in that conical frame-work called the Thorax. Though thus well protected from external injuries, it is nevertheless subject to many diseases. Its lining membrane may be the seat of inflammation, with its various effects, or its investing membrane may undergo morbid alterations, or the muscular substance that constitutes the organ itself may be gradually changed in its qualities, in its bulk, or in its proportions. Its office is no less es-

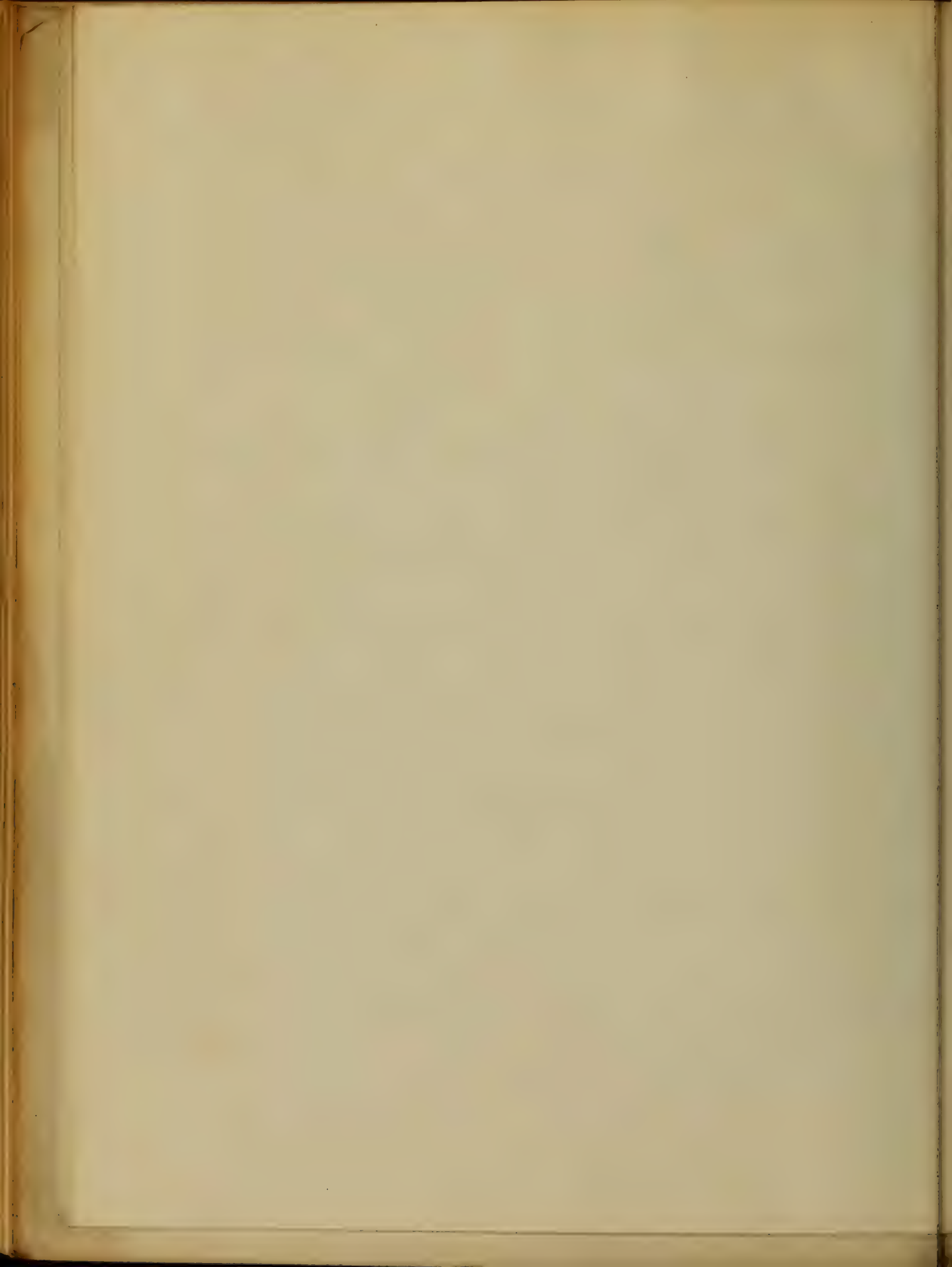


central is life and health, show that of the main
 or of the lungs, which with it constitute the "trifod
 of life". Its action begins early in foetal develop-
 ment, and ends only with life, having for its object
 the propulsion of the blood to the different tissues
 and organs and thus supply material for chem-
 ical action in fitting proportion that "the lamp
 of life may burn". Being such a vital organ its
 derangements are necessarily serious, and therefore
 to the physician most interesting. And of all the
 organs of the body, none are so prone to hyperaemia
 as the heart.

Development of different parts of the body,
 the cessation of growth of parts after an inherent
 principle of limitation, and the preservation of
 a definite size and form during the constant
 molecular changes incident to nutrition, are

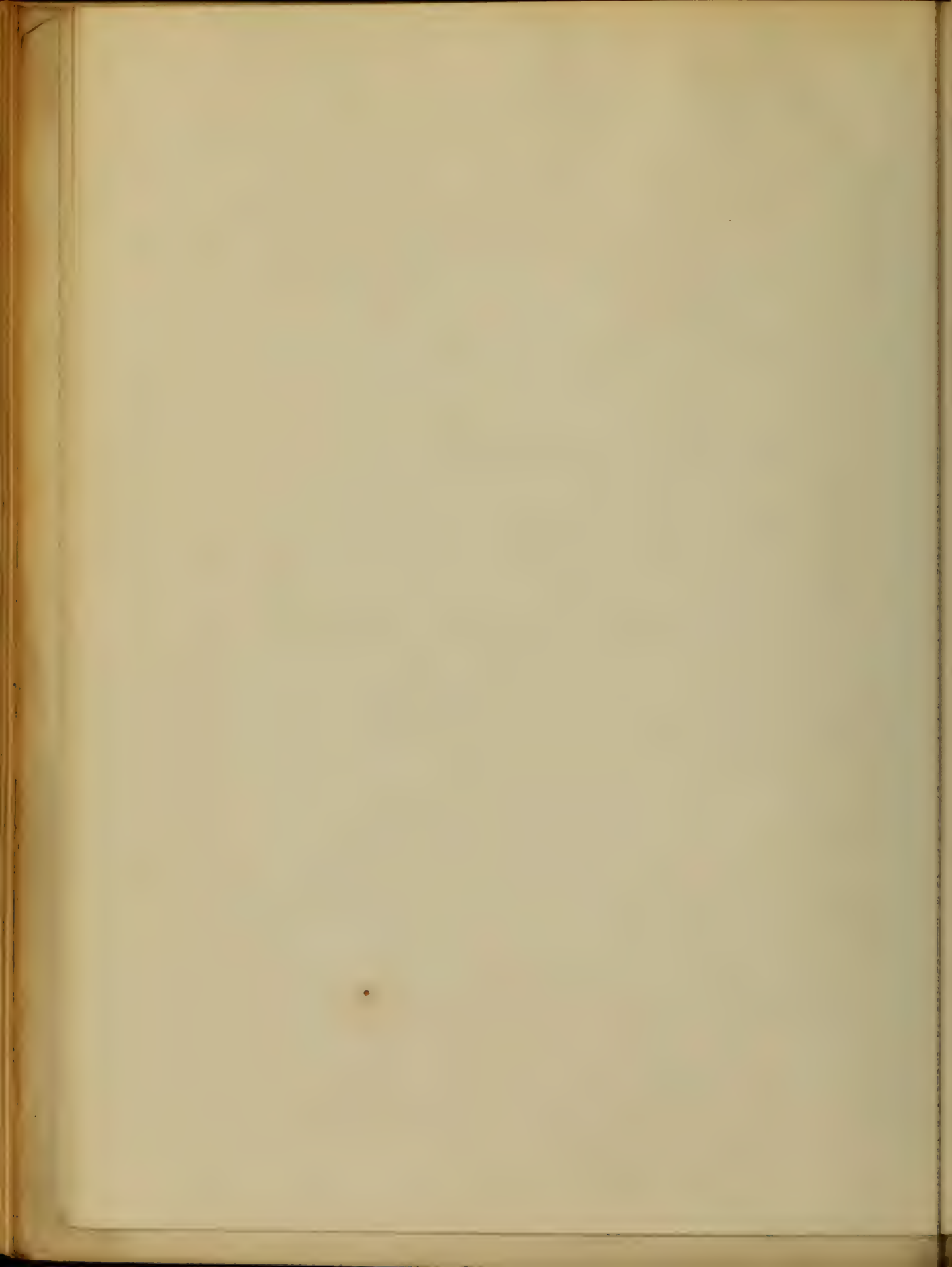


Physiological mysteries that have not yet been explained. Hypertrophy is a lesion of quantity and is properly applied to enlargement from an increase of the normal material, and involves an abnormal activity of nutrition and an exaggeration of that principle or force which determines the normal size and form of the different parts of the body. Enlargement from an accumulation of fat upon its surface and between the muscular substance, or by the presence of different morbid products in these situations, is not true hypertrophy, for under these circumstances, notwithstanding the abnormal volume and weight, the muscular substance may be diminished; that is, instead of hypertrophy, there is atrophy of the organ. In hypertrophy the normal balance between



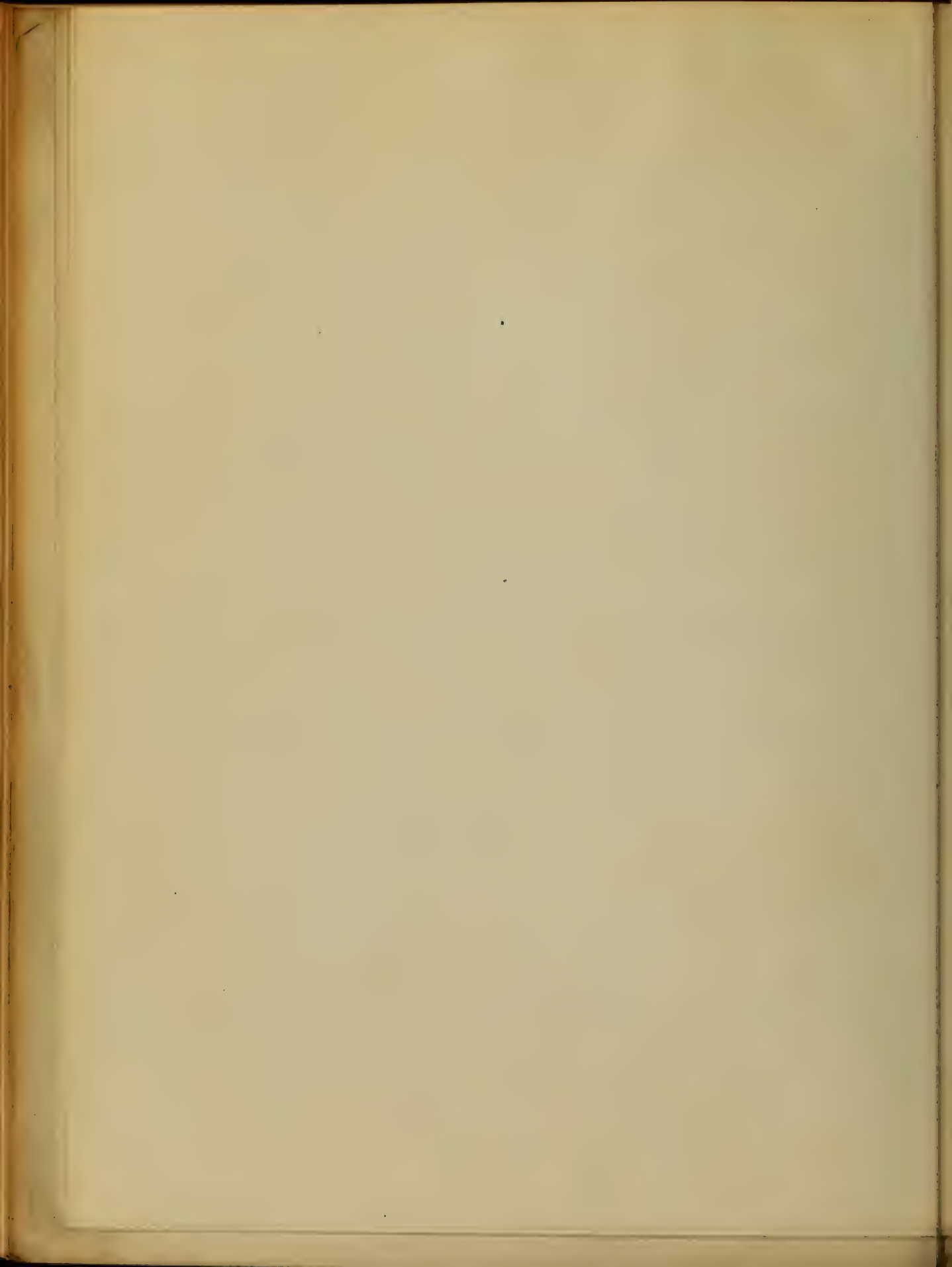
the appropriation of nutritive material and destructive assimilation in the fat is disturbed by the former being in excess. The best illustrations of it are in the huge fleshy masses visibly prominent in the arm of the blacksmith or the lower limbs of the pedestrian.

Etiology.— The law prevails in the animal economy, that increase of function leads to augmentation of bulk. The function of muscular tissue is contraction and the more frequent and energetic contractions beget an addition of substance. And the muscular walls of the heart increase in bulk precisely as the voluntary muscles become so when persistently exercised; hence true hypertrophy occurs whenever the function of the organ is permanently or repeatedly overtasked, and when the resistance

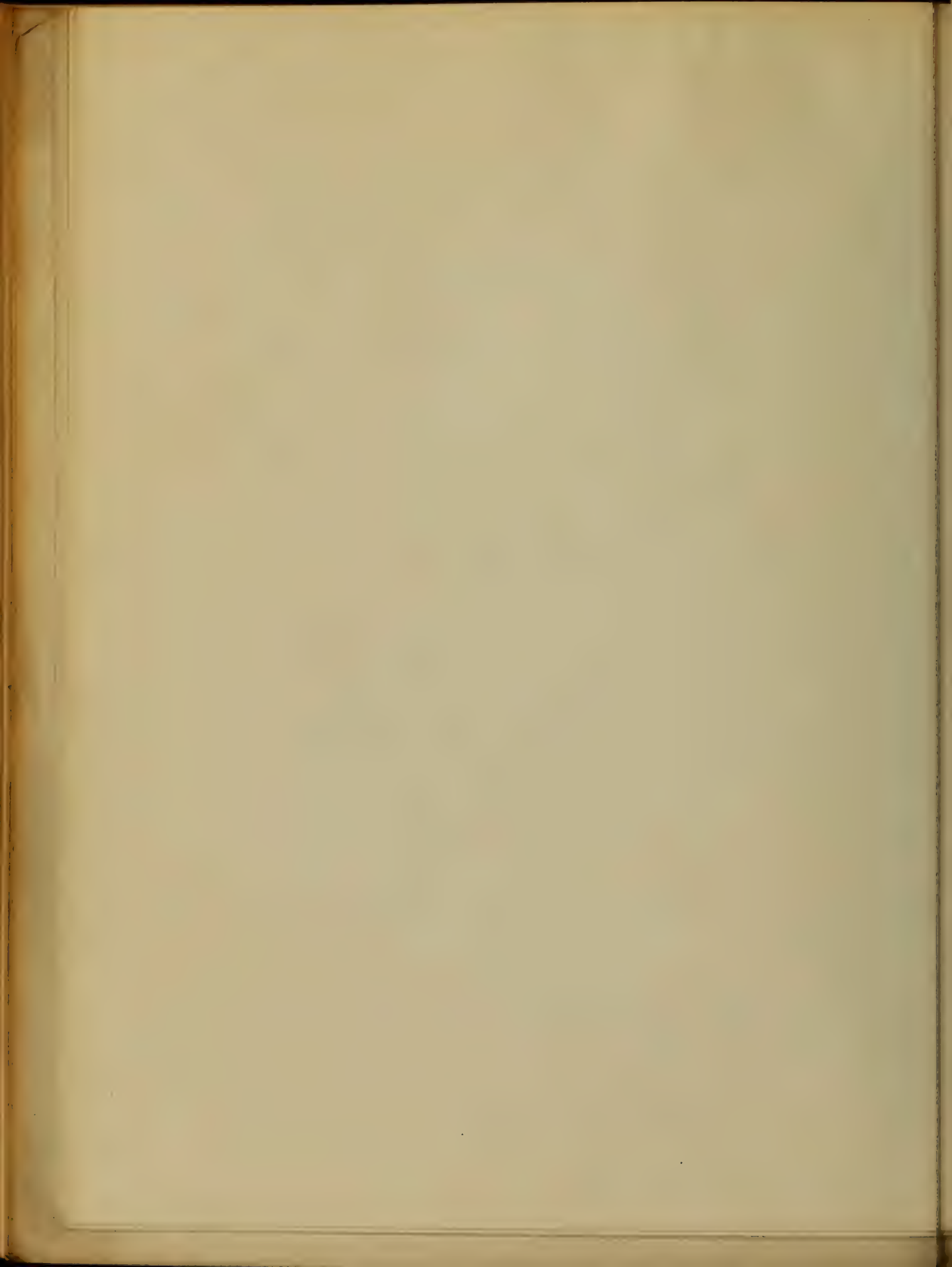


which it should normally encounter is increased.

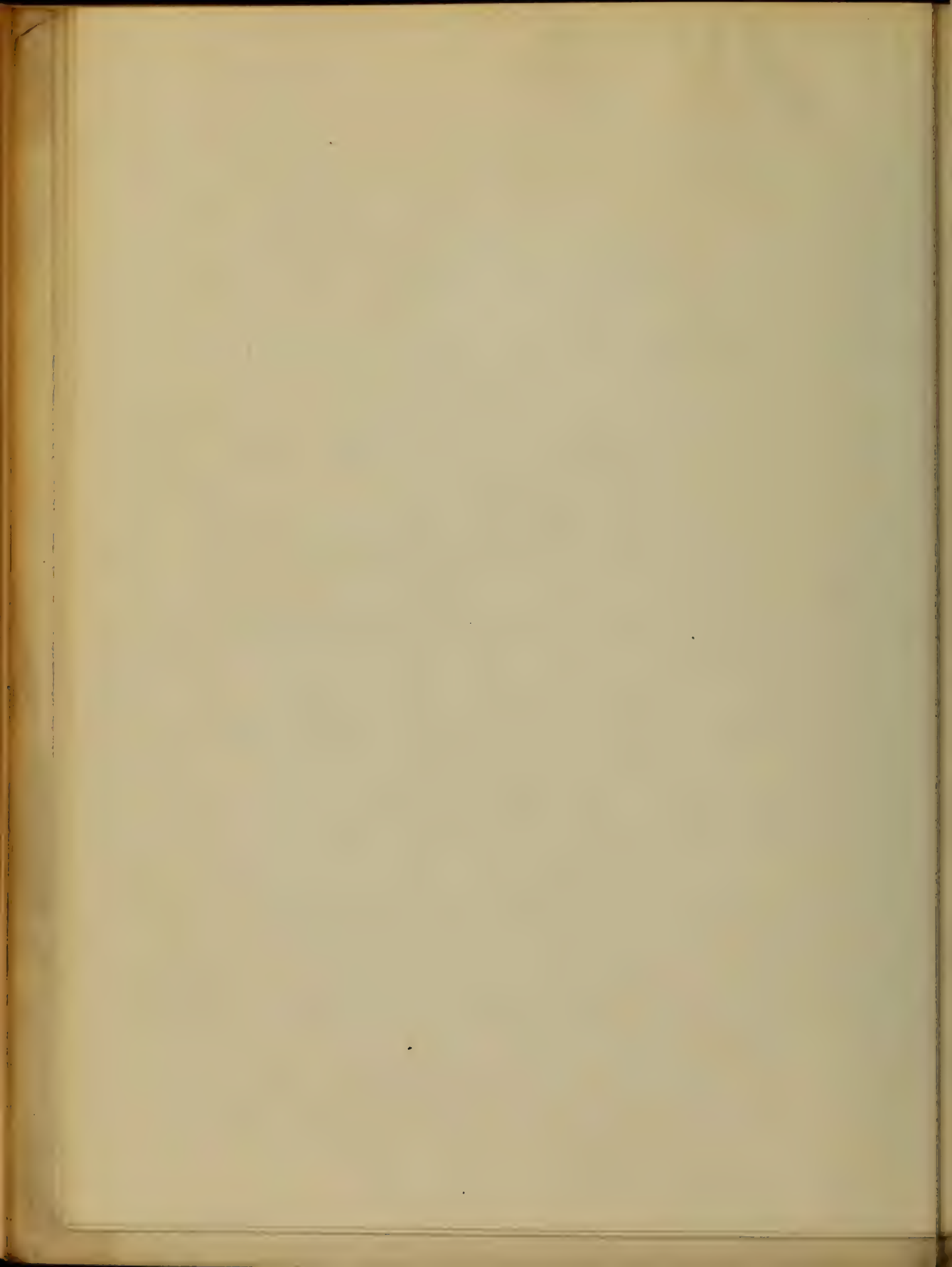
Of all causes, valvular lesions are the most fruitful in its production. The valvular cusps and segments may be thickened and contracted, or simply encumbered with vegetations, or rendered rigid by calcareous deposits. The several portions of the heart may collectively participate in the enlargement, or it may be confined to one or more of the anatomical divisions without extending to the whole organ. Of the several portions, the left ventricle is oftenest enlarged; next in liability to enlargement is the corresponding auricle; next the right ventricle, and last, the right auricle. The valvular lesions which especially lead to hypertrophy of the left ventricle, are seated at the aortic orifice, and they may involve either contraction and consequent



by obstruction, or incompetency of the valves and
 consequent regurgitation of the blood from
 the aorta into the ventricular cavity, or both
 combined. Enlargement commences in the left
 auricle in connection with lesions affecting the
 mitral orifice and valves, and involving either
 stenosis or insufficiency of the valves. It then
 leads to accumulation of blood in the left
 auricle, the passage of it from the auricle to
 the ventricle being impeded by obstructive lesions,
 and a retrograde current from the ventricle to
 the auricle being incident to lesions which ren-
 der the valves incompetent. Then follow pul-
 monary congestion, and consequent upon this,
 enlargement of the right ventricle. So far as
 ventricles are concerned in connection with mitral
 lesions, the right is first enlarged, and its

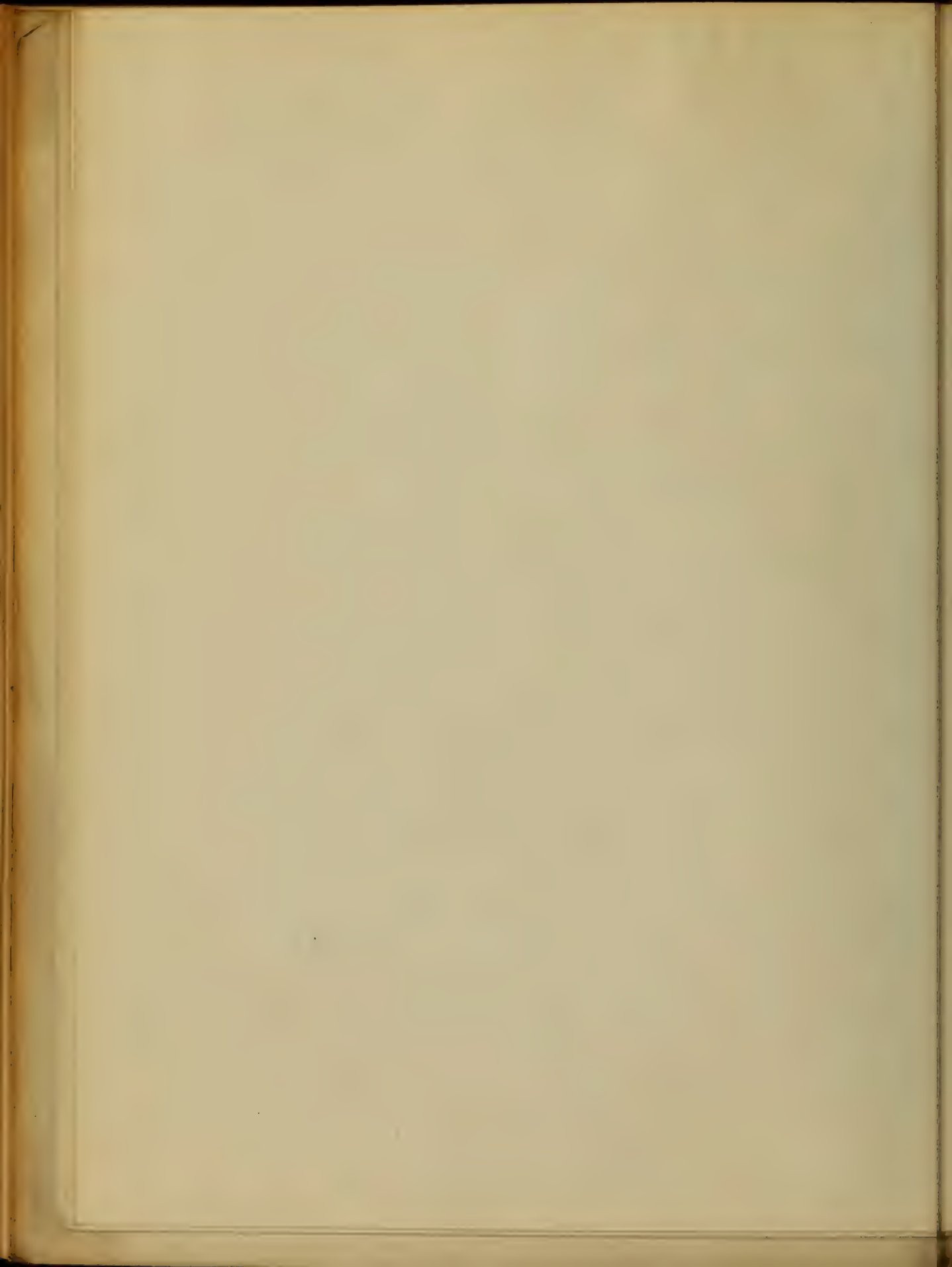


enlargement preponderates over that of the
 left, unless aortic lesions also exist. Enlargement
 of the right, leads ultimately to that of the left
 ventricle, partly from the muscular fibres com-
 mon to both ventricles, and in fact from the
 ultimate effect on the left ventricle of obstructive
 accumulation successively in the right auricle and
 the systemic veins. Lesions on the right side of
 the heart are comparatively so infrequent that
 little need be said of them. Contraction and
 valvular insufficiency at the orifice of the pul-
 monary artery, give rise primarily to enlarge-
 ment of the left ventricle. Lesions at the
 tricuspid orifice being extremely infrequent, en-
 largement of the right auricle rarely occurs,
 except consecutively to an affection of the right
 ventricle. All these lesions cause augmented

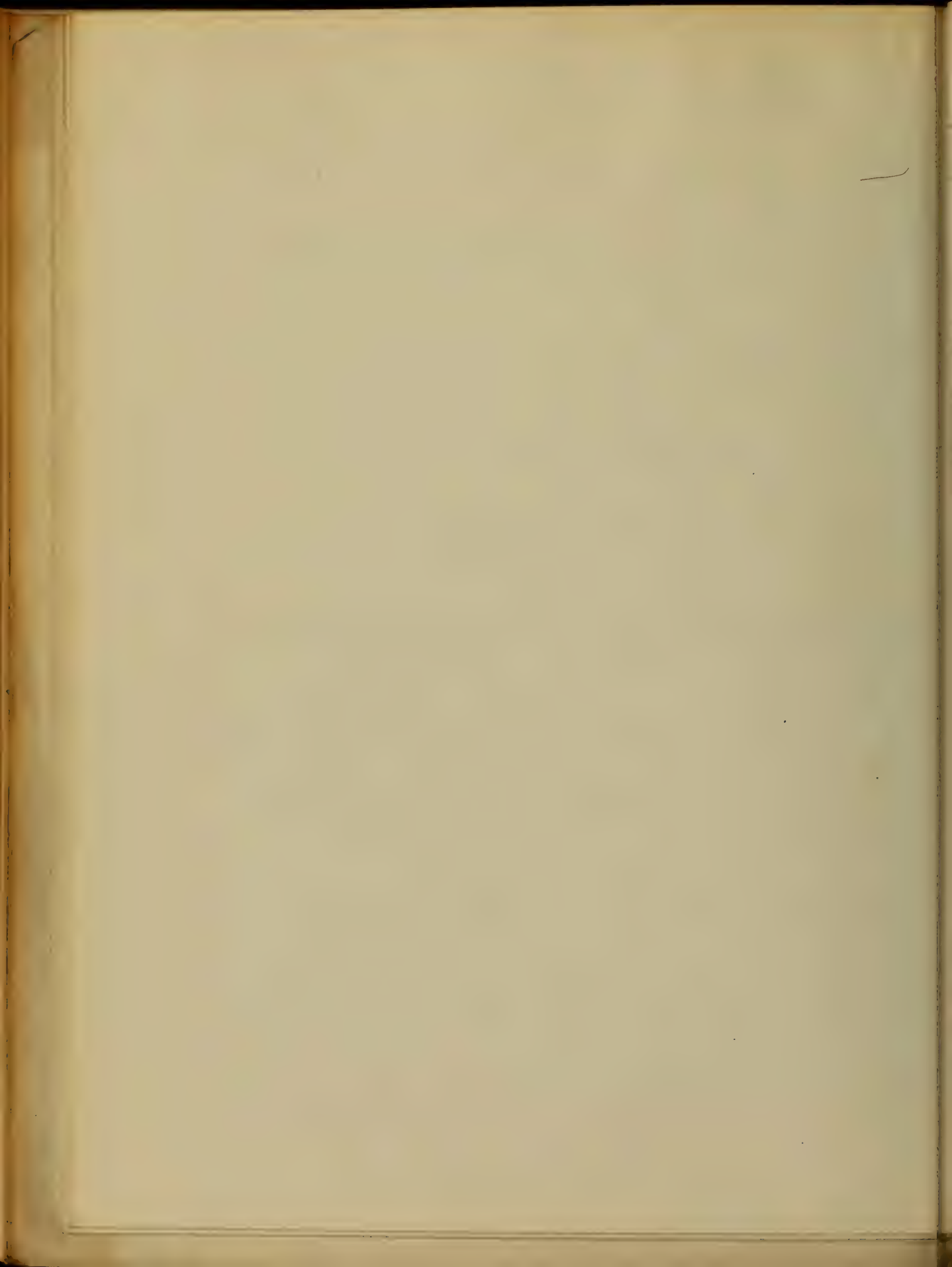


action of the heart, in order to overcome the impediments and carry on the circulation.

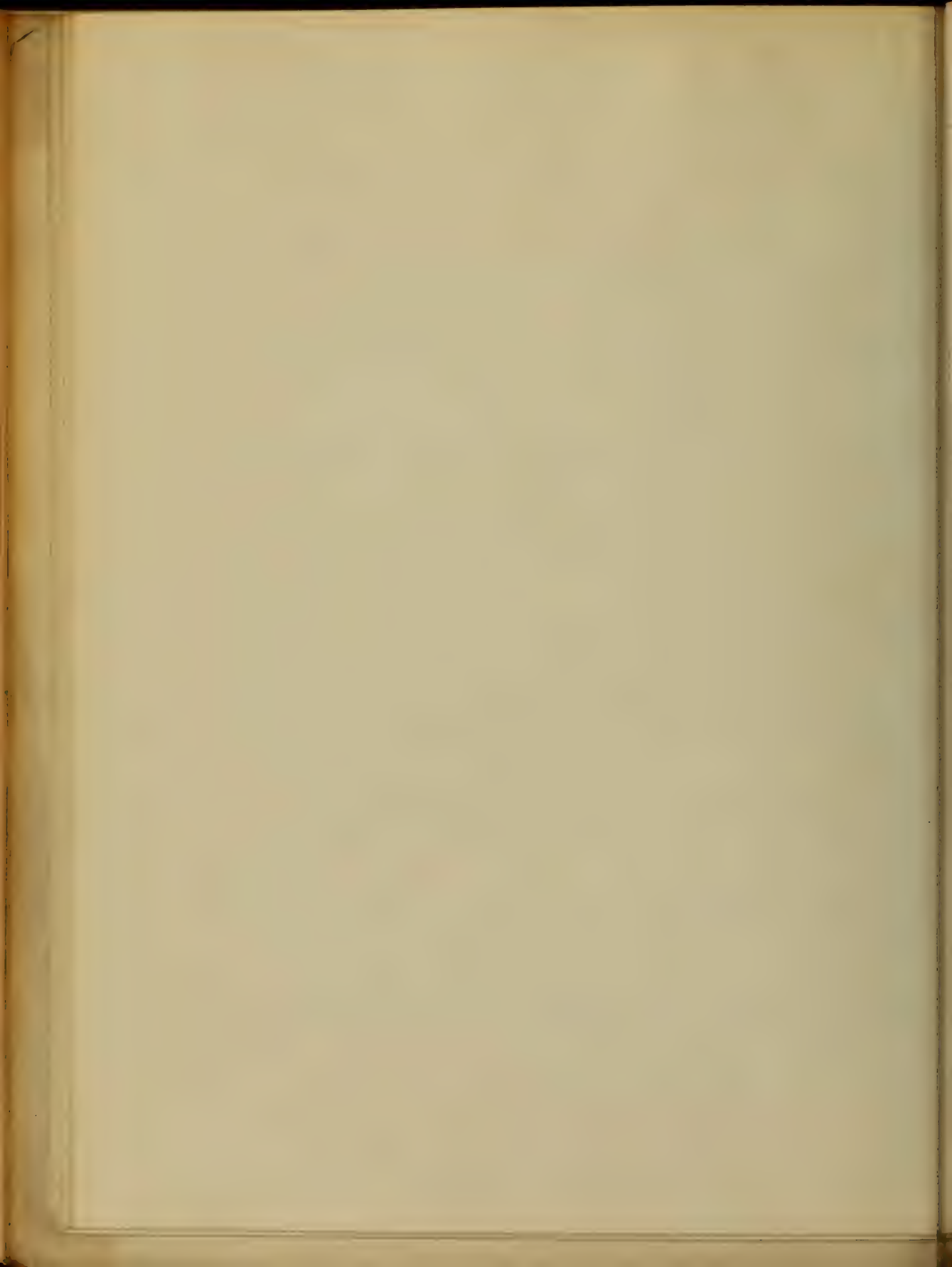
Besides valvular lesions, atheromatous and calcareous disease of the aorta may have the same effect, the diminished elasticity of the walls of this vessel, constituting an obstacle to the circulation, and thus leading to increased power of the contraction of the left ventricle. Obstruction in the same vessel from aneurysm, is often associated with lesions at the aortic orifice, involving either contraction, or regurgitation, or both. Degenerative changes in the other arteries, as atheroma widely diffused throughout their walls, the vessels becoming elongated and tortuous, so that friction is increased, that is of the blood against the sides of the arteries, but the elasticity of their coats is seriously dimin-



ished. So too the enlarged area of the arterial branches occasioned by copulency. Enlargement, either limited to, or predominating in the left ventricle, occurs as a concomitant of chronic Bright's diseases. The blood being impeded in its passage through the minute systemic vessels owing to the contamination by excrementitious materials in consequence of the renal degeneration; and the left ventricle has to make extraordinary efforts to propel the blood. Chronic pulmonary and vesicular emphysema may cause hypertrophy in the right ventricle. Even persisting functional disorder may eventuate in the production of enlargement of the heart. Hypertrophy is conservative though, and especially in the left side of the heart. In lesions of the aortic valves hypertrophy of the left ventricle ren-

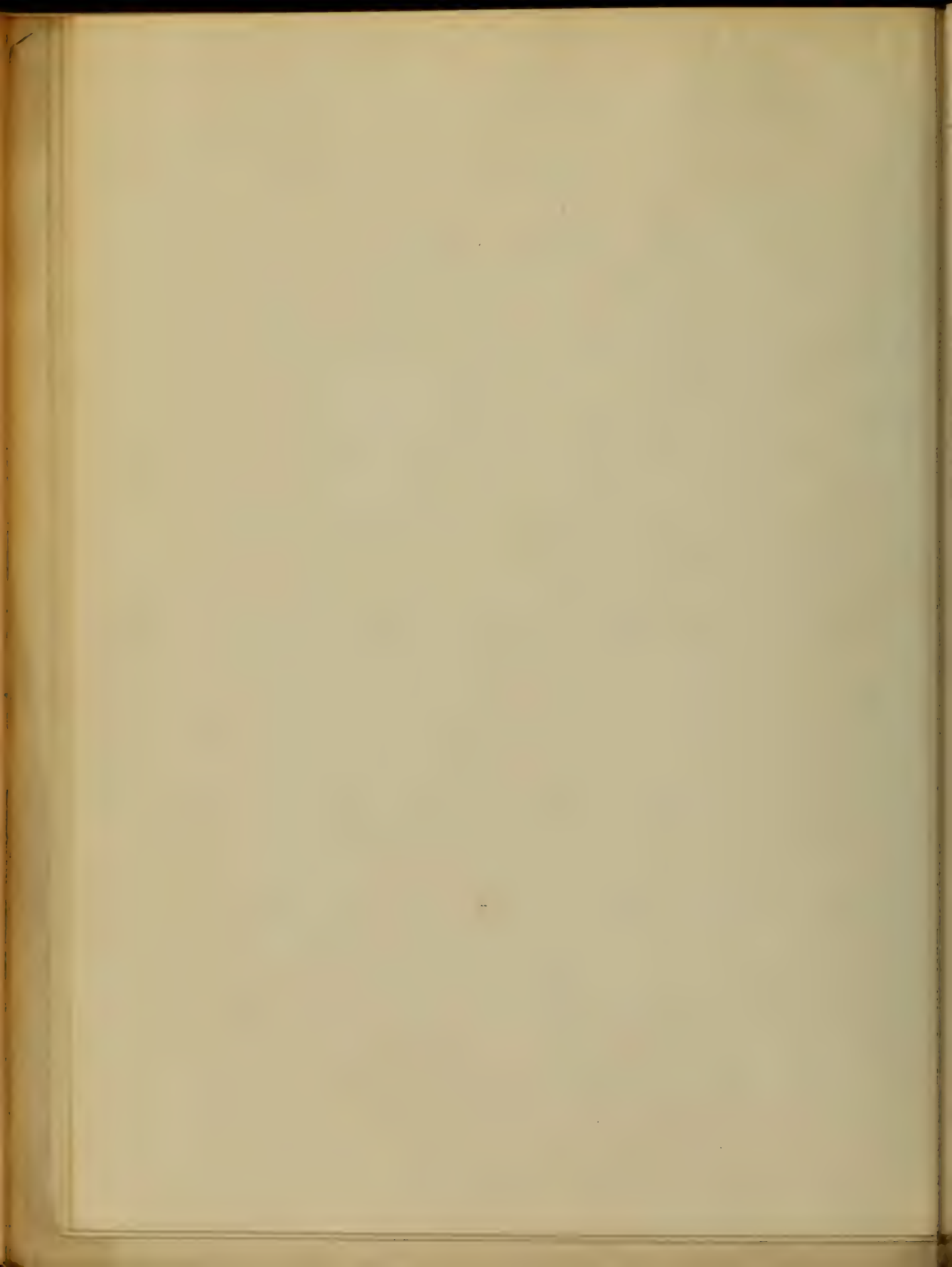


realizes the baneful influence of the defective
 valves. While the latter tends to retard the
 circulation of the blood, and to render it venous,
 hypertrophy accelerates its course and makes
 it arterial. While valvular deformities causes
 decrease of the contents of the aorta, hypertrophy
 renders the aorta fuller. While deficiency of the
 valves hinders the outflow from the pulmonary
 veins, and lets the circulation lesser, overcharge
 itself with blood, hypertrophy facilitates such
 outflow, and relieves the pressure upon the
 pulmonary system. Hence hypertrophy in
 most cases is conducive to the welfare of the econ-
 omy in view of the circumstances under which it
 occurs, and is nature's resource by which im-
 pending danger is postponed and existence pro-
 longed; for the augmented power of action which

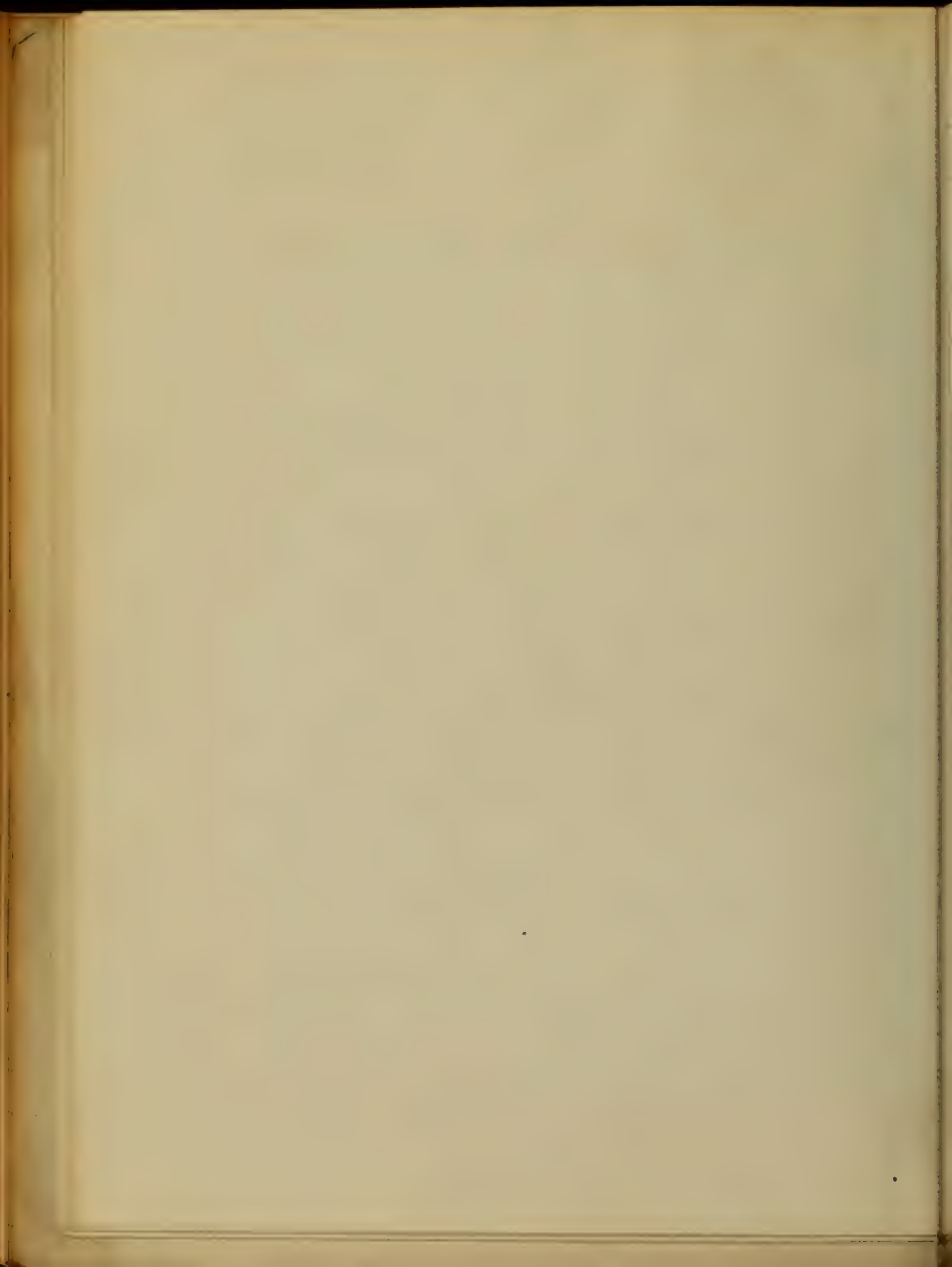


which the heart acquires with its increased muscular growth enables it better to carry on the circulation despite the obstacles afforded by obstructive and regurgitant lesions. Hence we see that it is compensatory and that the mechanism of its production is the same in all these cases, namely, long continued augmented force of the heart's action.

Anatomical Appearances.— The prevalent weight of the heart in health, in the male, varies from ten to twelve ounces; in the female from eight to ten. It may become hypertrophied to such an extent that it is five or six times heavier than normal. The thickness of the left ventricle is not far from half an inch in the male, and a fraction less in the female. That of the right ventricle is a

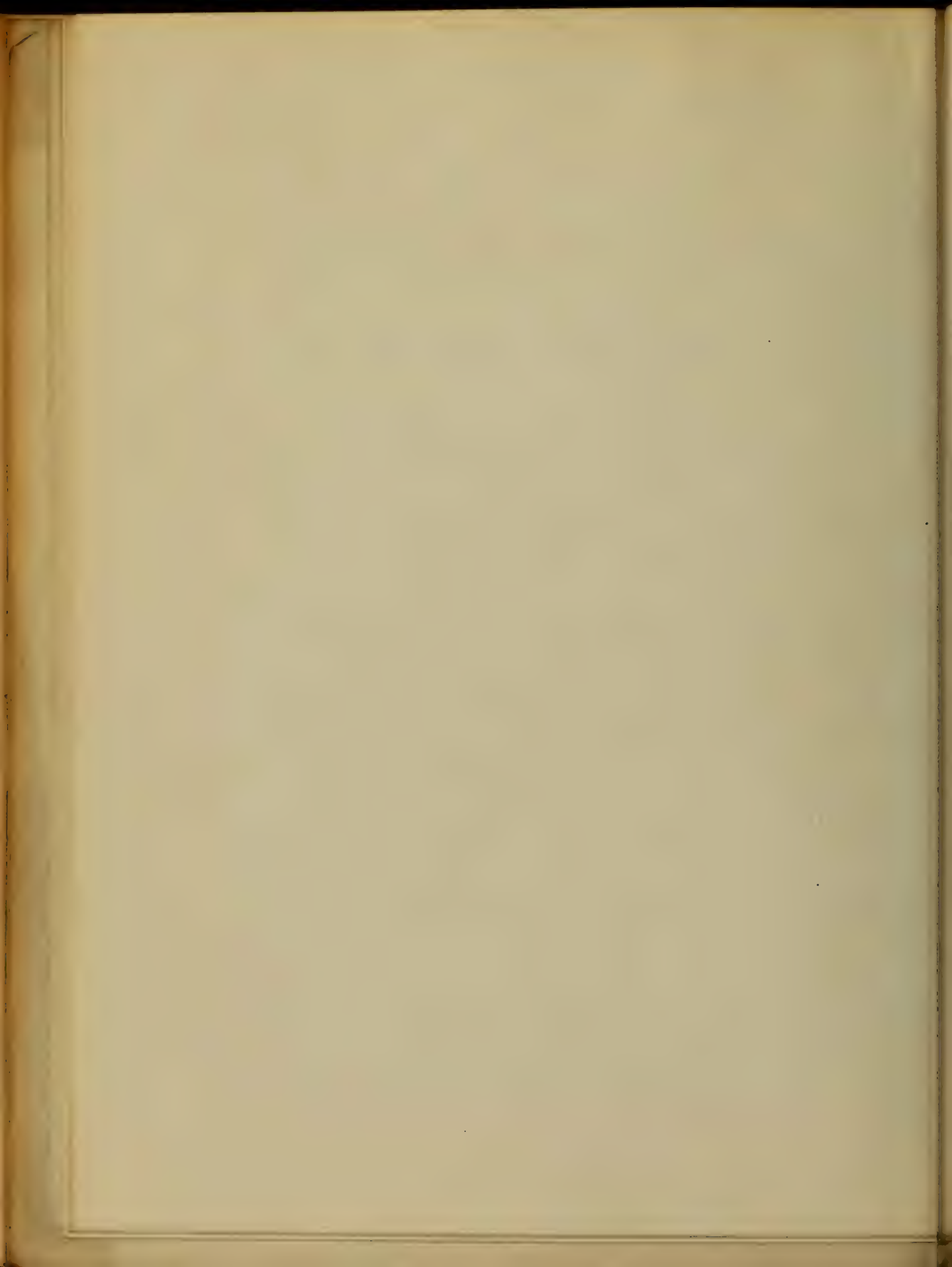


little over one-sixth of an inch in the male,
 and in the female somewhat less. The average
 thickness of the right auricle is about a
 twelfth of an inch, and of the left somewhat
 greater. The increase in thickness and weight
 of the different parts corresponds to the amount
 of hypertrophy of the part. The normal shape of
 the organ is conical; in hypertrophy of the
 right ventricle, the organ grows broader, and as-
 sumes a more spherical form. If limited to the
 left ventricle the organ is longer, and the lower
 end of the right ventricle does not extend so far downwards
 toward the apex as it otherwise should. The
 walls of a hypertrophic heart are rigid and
 hard, and the lumen is also abnormally large. The
 situation of the heart passes more into the horizon-
 tal direction, so that the base looks toward the

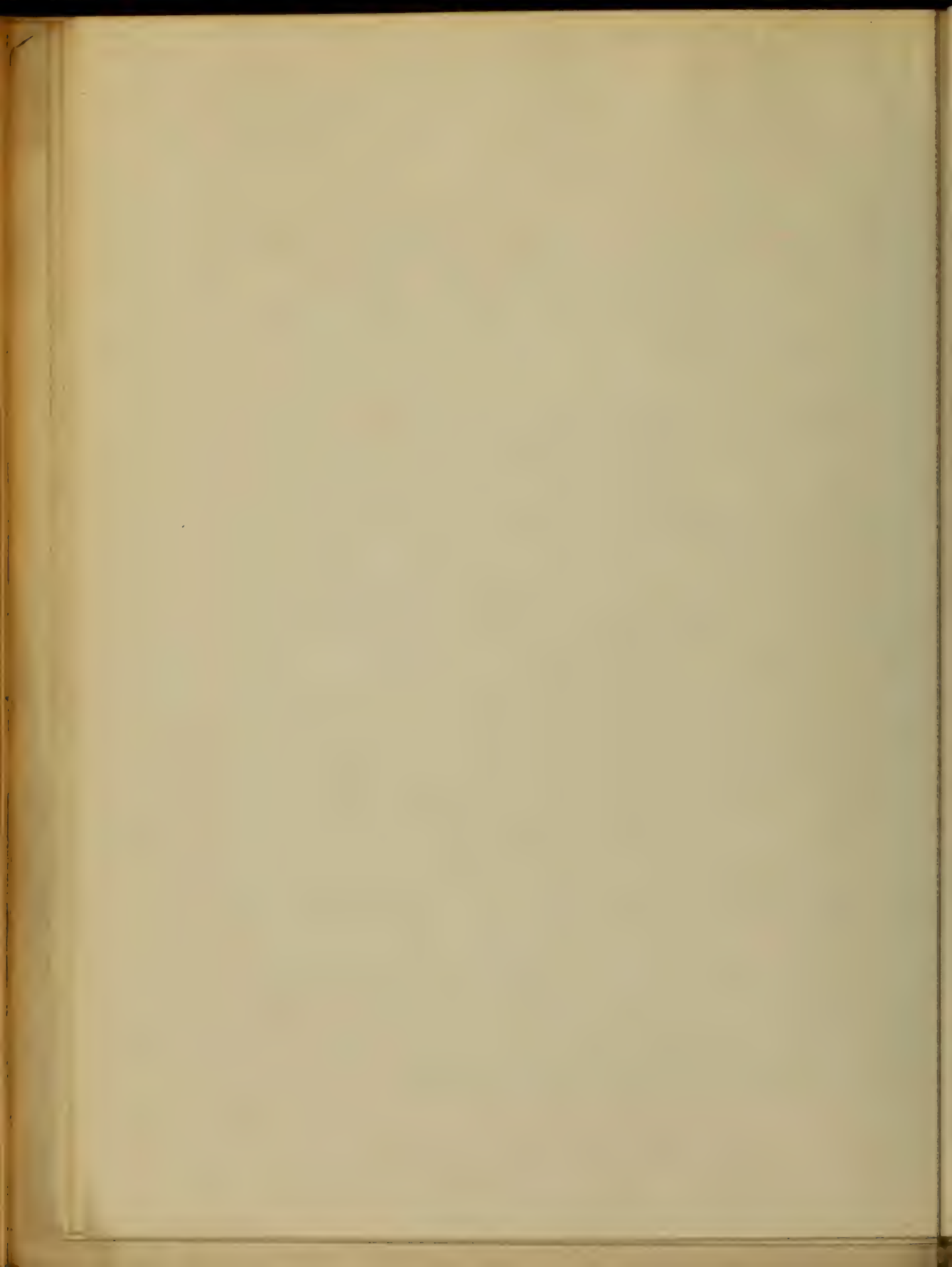


right and the apex towards the left. When the ventricular walls are thickened, the papillary muscles are not infrequently more or less increased in size. Simple hypertrophy gives rise to thickening of the muscular fasciæ of one or more of the cavities; in eccentric, the walls become thicker and the chambers larger than normal; and the concentric variety is accompanied with diminution in the size of the cavity. This last occurs only as a congenital malformation, and never as a consequence of disease.

Symptoms and Course.— Simple hypertrophy of the heart, scarcely ever exists alone, or independently, but is the accompaniment of other grave diseases of the organ, or great vessels, these complications often neutralize the effect which it

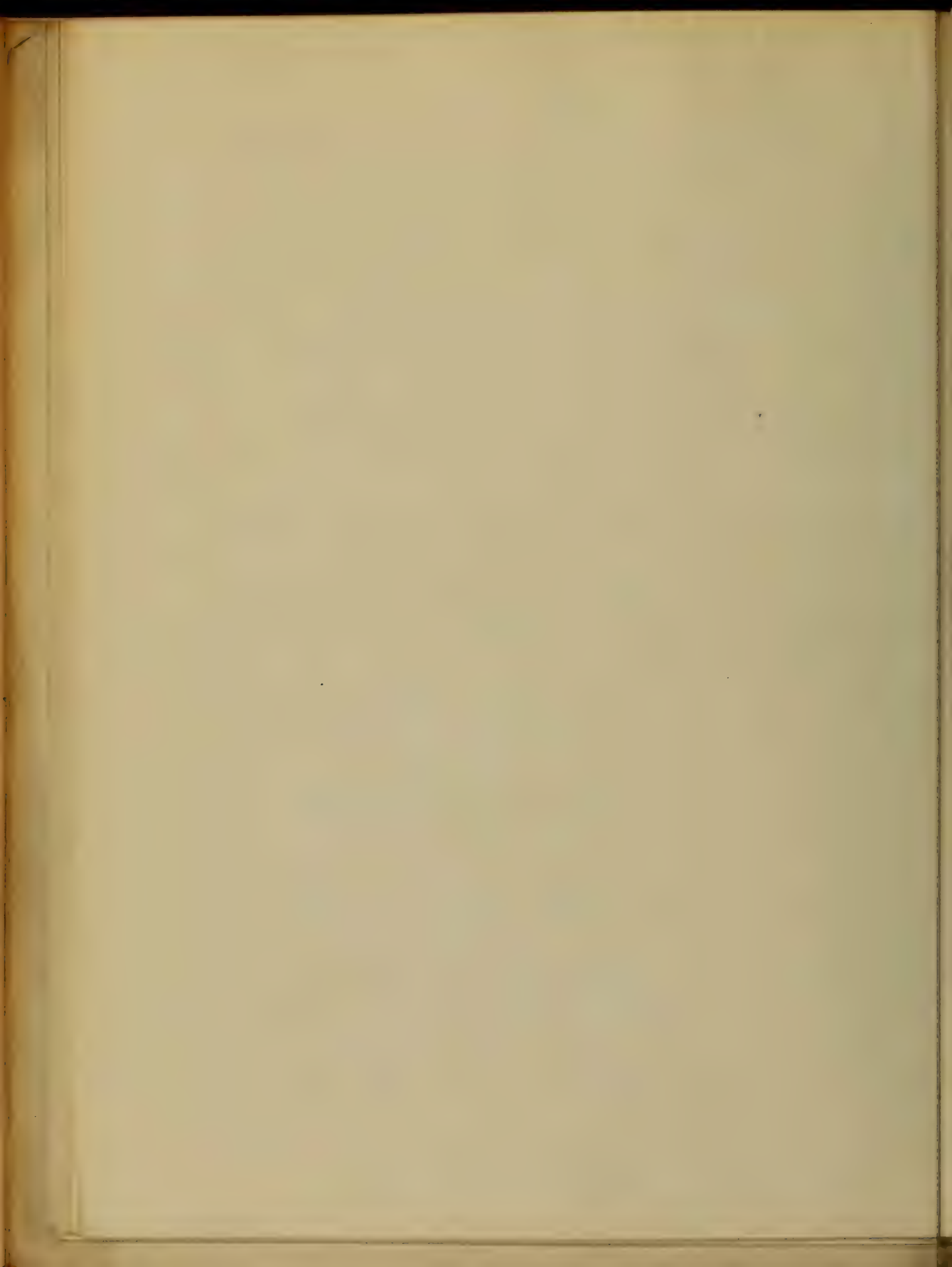


would have, were it to exist alone. When insufficiently enlarged to displace the lungs to either side, and depress the diaphragm, there may be a sensation of fulness in the chest, of fulness in the epigastrium, and often of a considerable degree of shortness of breath. In absence of aortic and mitral lesions involving obstruction or regurgitation, the pulse would represent by its force and fulness, the power of the ventricular systole. Dyspnoea, when, from any cause the action of the heart is increased, as after exercise, would denote that the hypertrophy affected the right ventricle. The frequency of apoplexies of the brain is due in part to the fact that the vessels of the brain are thinner than those of other organs, and hence more liable to rupture when unduly distended; and in part also, to the



circumstance that the coats of the arteries in
 hypertrophy of the heart are often altered.

After dilation and systemic irrigation have
 taken place, effusion begins about the viscera,
 and afterwards occurs in the areolar tissue of
 other parts and into the serous coats, and increases
 dyspnoea and adds symptoms incident to the
 anasarca. When dyspnoea becomes a prom-
 inent symptom loss of sleep adds to the sufferings
 of the patient; that which is obtained is apt
 to be imperfect and disturbed by frightful dreams.
 In the wards of the University Hospital of
 Maryland, I have seen patients in this condi-
 tion unable to lie down for many days before
 death, short periods of sleep being obtained by
 inclining the body forward and resting the elbows
 on the knees, or on the bed. The appetite and



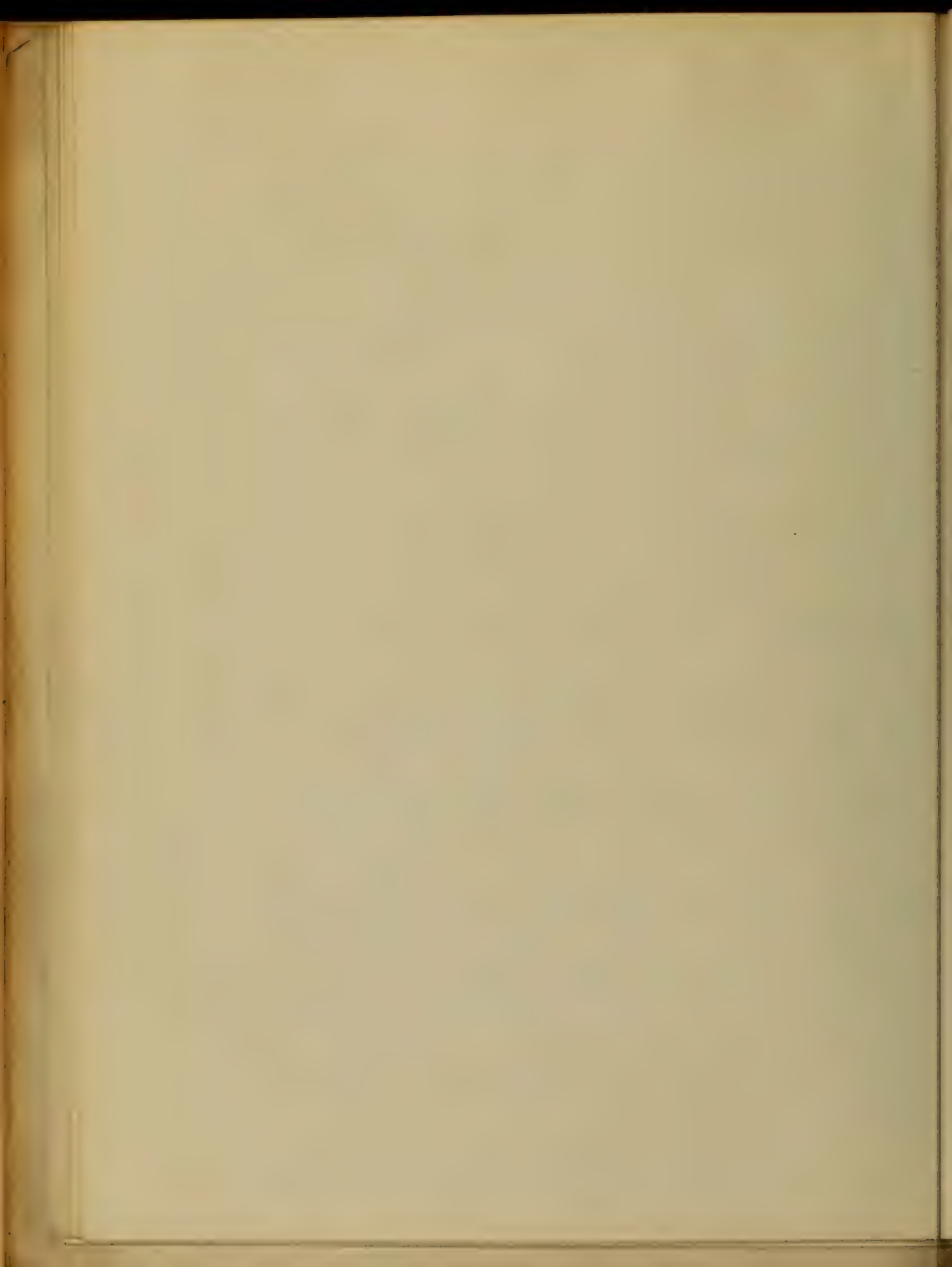
digestion then become impaired, but emaciation is not a marked effect, Albumenuria may occur, owing to the renal congestion.

Physical Signs.— The diagnosis of this affection must rest on physical signs. The symptoms may point to this lesion, and, afford corroborative evidence of its existence, but they are not adequate to lead to any positive conclusion.

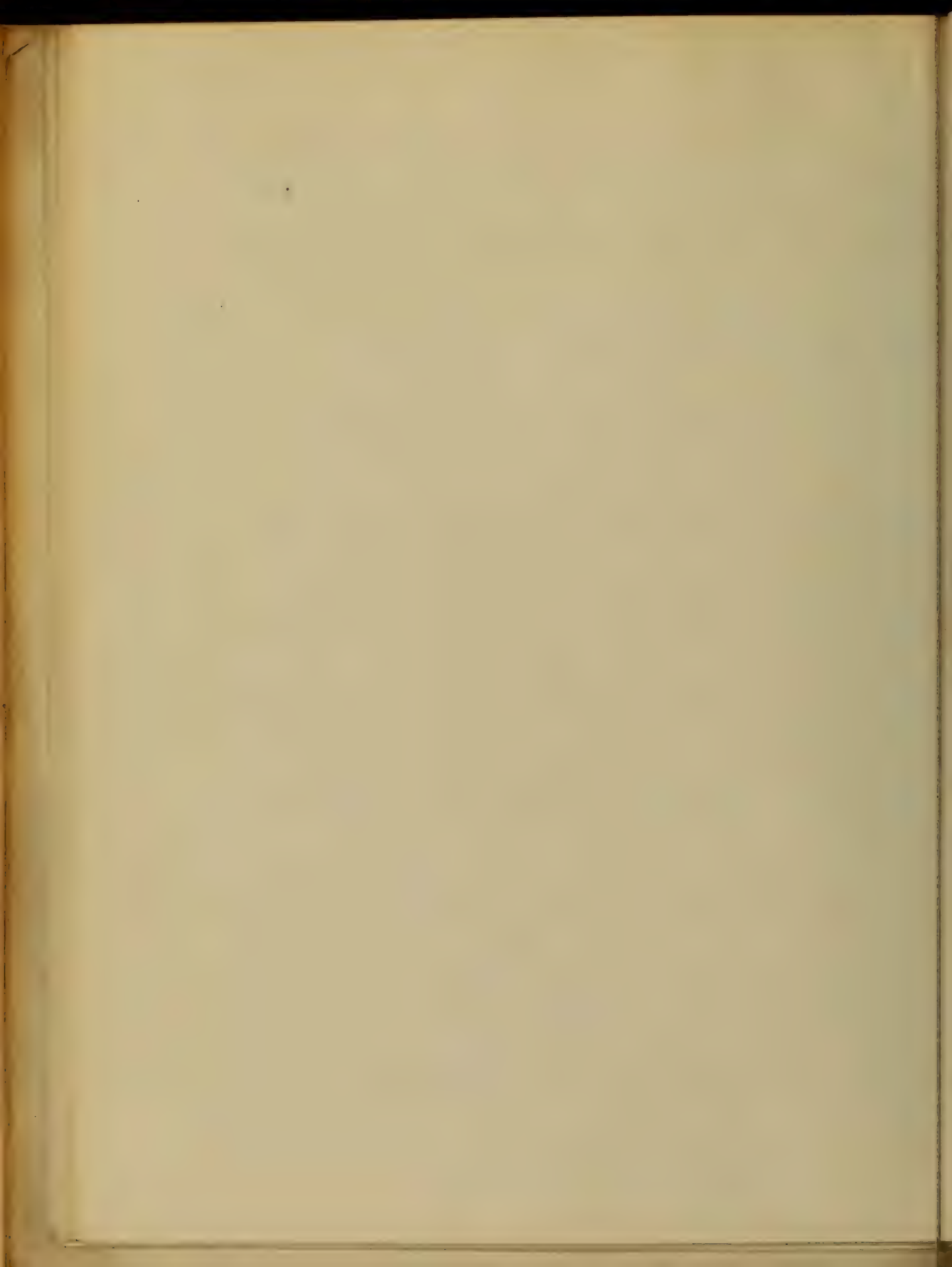
Inspection.— Shows the visible impulse to be increased in extent and force, and especially if dilatation of its cavities attend the hypertrophy.

Measurement.— Shows increased size of the chest.

Palpation.— The impulse has a heaving, lifting character, and the area greatly exceeds that within which the normal apex beat is felt. When the left side is hypertrophied, the apex beat reaches further to the left than natural, and below the



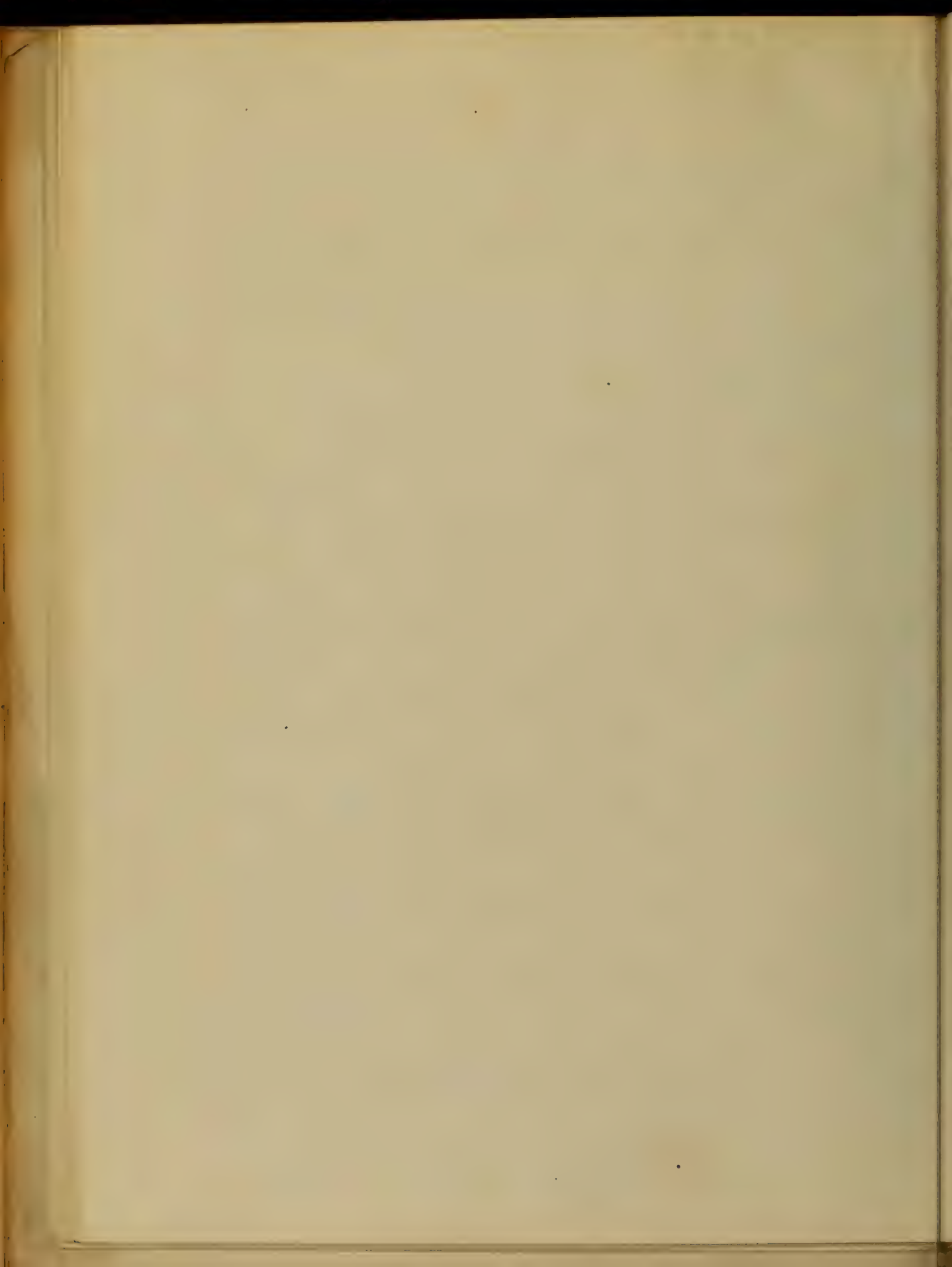
normal position. Abnormal conditions extrinsic
 to the heart alter the relations of the apex to the
 walls of the chest, such as enlargement of the
 left lobe of the liver, distension of the stomach,
 ascites, and enlarged spleen, but these do not
 lower it. Such conditions must be excluded
 before the abnormal situation of the apex can
 be regarded as a sign of enlargement of the
 heart. The force of the beat and lifting impulse
 show that the enlargement is due to hypertrophy
 rather than dilatation, or that the former pre-
 dominates. The sensation in palpitations is
 that of increased action, and in hypertrophy
 of increased power, and the impulse prolonged.
 Percussion.— The area of dulness increases later-
 ally and downwards. If confined to the left
 ventricle, then the dulness may extend considerably



beyond the left nipple. While on the other hand, when confined to the right ventricle, the dulness may extend considerably to the right of the sternum.

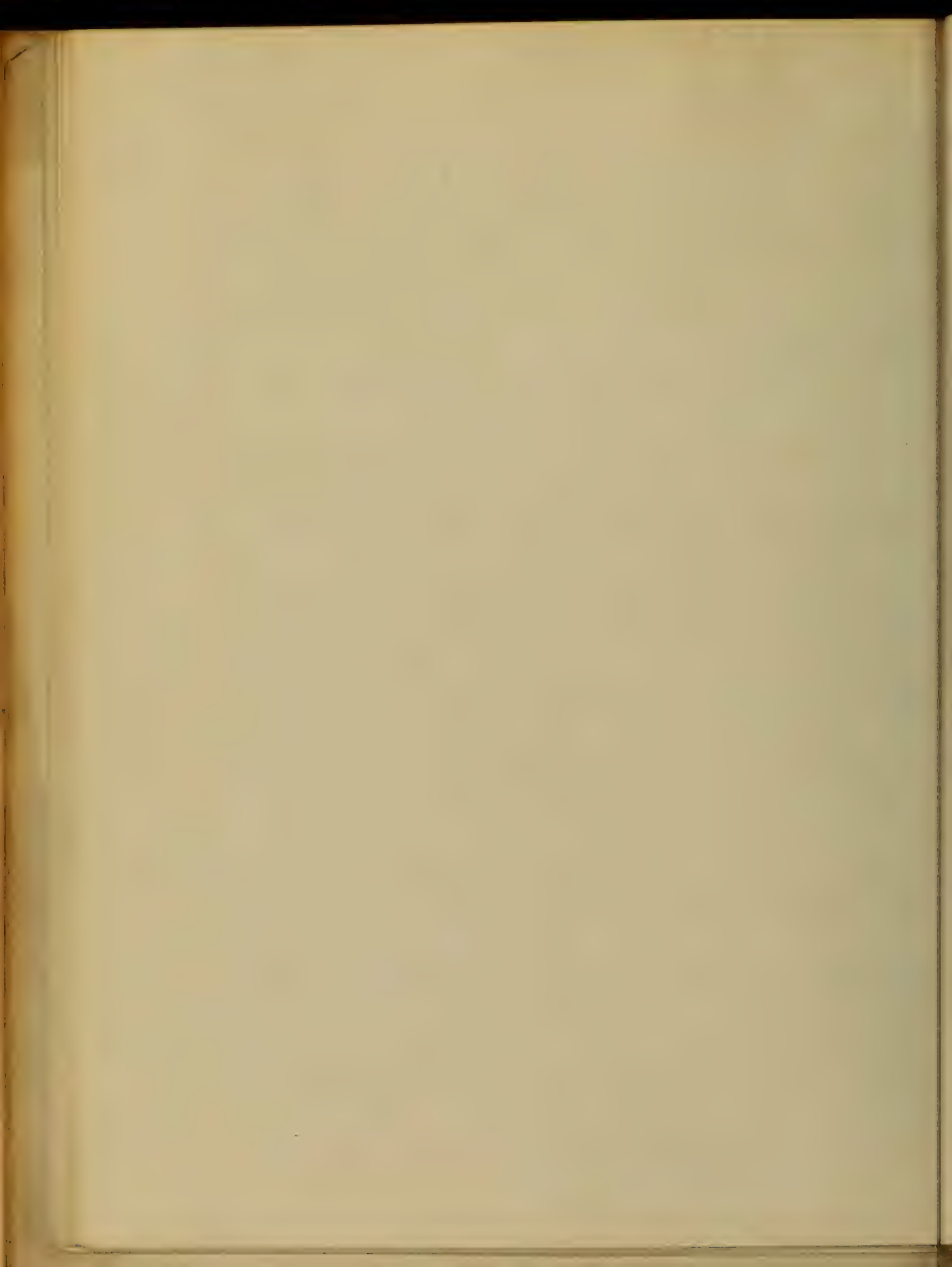
Auscultation.— The aortic sound is intensified, dull and prolonged in hypertrophy of the left ventricle. Simultaneous intensity of aortic and pulmonary sounds separately, is a sign of hypertrophy affecting in the one case the left, and in the other, the right ~~ventricle~~. Not only is the murmur in tranquil breathing over the cardiac region inappreciable, but may not be discoverable although the breathing be forced.

Prognosis.— Hypertrophy of the heart admits of a very favorable prognosis, accepting the narrowest meaning of the term. And in many diseases of the heart in which it is found as a



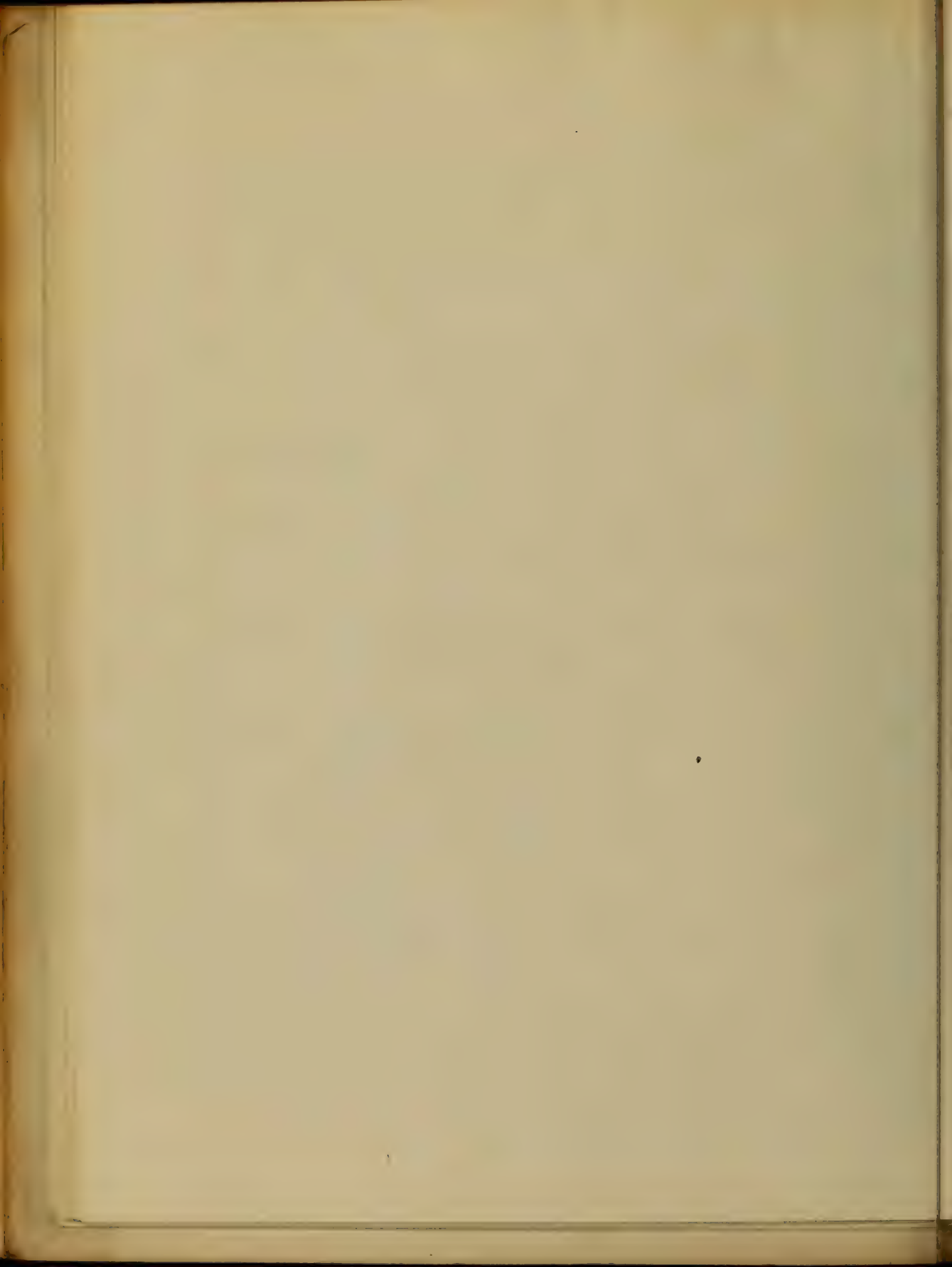
complication, it is compensatory and actually mitigates the danger of the chief disease. With the transition from genuine to furious hypertrophy, the picture changes and many dangers arise.

Treatment.— Study and investigation have removed parts of the tangled web which once clouded the pathology of this disease, and hence its treatment is better understood now than formerly. It must be remembered, that enlargement of the heart by hypertrophy, as a rule is compensatory, or in other words, a conservative provision to meet the difficulties incident to the morbid conditions upon which the hypertrophy depends. Valvular lesions, pulmonary emphysema and Bright's disease are not of a nature to admit of removal; but some-

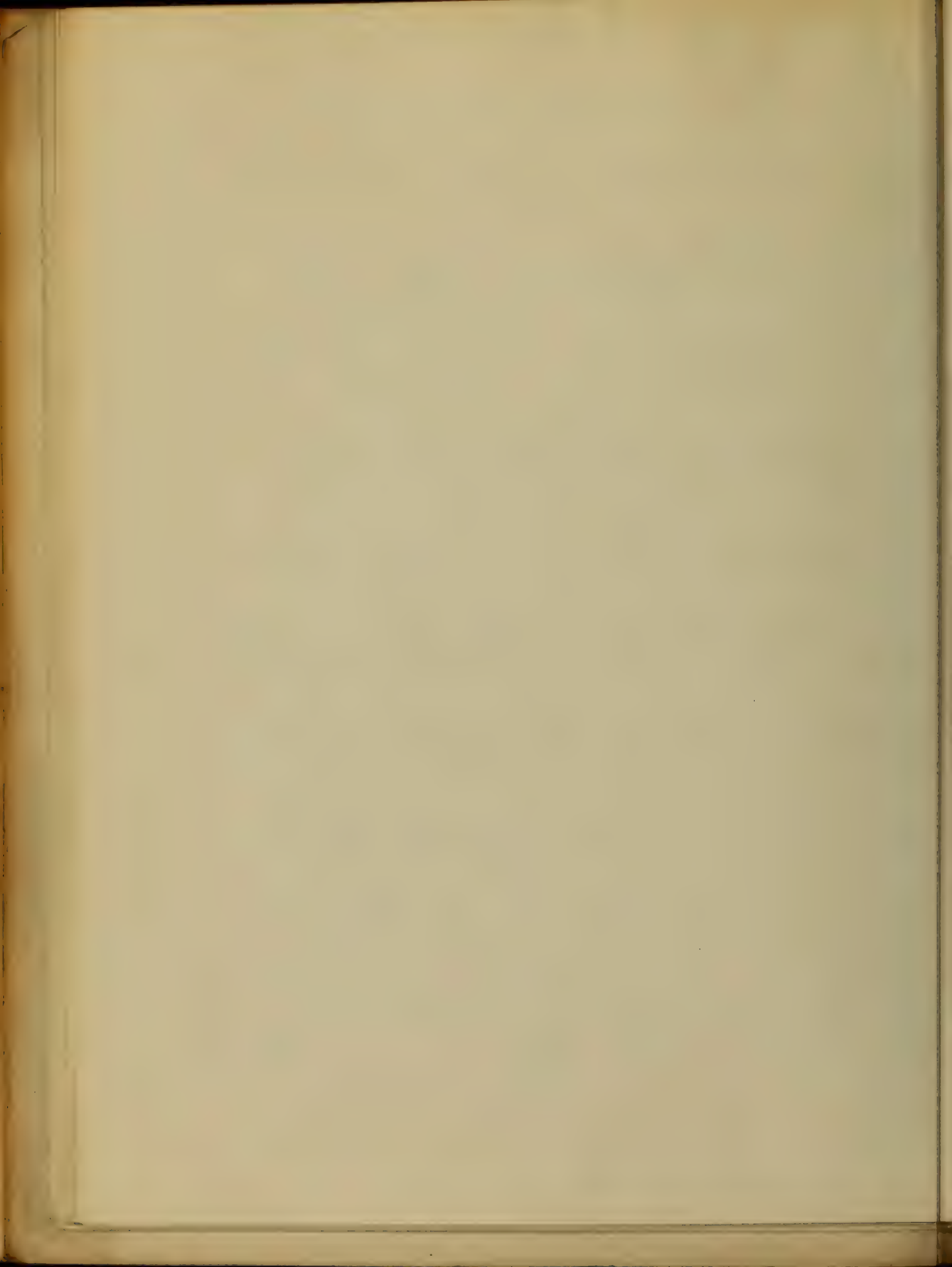


Nothing can be done towards preventing or limiting
 impediments to the circulation, by avoiding
 extrinsic causes which excite unduly the action
 of the heart and the employment of measures
 designed to equalize and tranquillize the circula-
 tion. The diet should be nutritious. The appetite
 and digestion, if impaired, should be improved
 by tonic remedies. Moderate exercise in the open
 air is to be encouraged, very active exertions being
 of course interdicted. When dilatation occurs,
 digitalis is a valuable remedy, appearing to re-
 lieve irregularity of the heart's action without
 diminishing, but, on the contrary, increasing the
 power of ventricular contraction. The following
 is a favorite prescription of Prof. F. Donaldson.

℞ - ℞. Digitalis ꝑ℞
 ℞. Rhusuml ꝑ℞ xx. M. et Sig. Take t-d.



Dyspnoea and other pulmonary symptoms are sources of annoyance. Ether and mild iodine applications to the chest or dry cupping may mitigate the dyspnoea. Opium to check expectoration will likely increase the distress. Should general dropsy exist, it should be met by diuretics and hydragogue cathartics. The digitalis acts well here by augmenting the tone and contractility of the vessels, besides moderating the action of the heart, thus restoring the balance of the circulation, and relieving the congested kidneys, permits their secretion to take place freely. It is in cardiac dropsy that diuretics are more likely to effect the absorption of the effused liquid than in renal; for, in the latter, the kidneys being diseased, rarely respond to diuretics. Hydragogue cathartic



come next. *Elaterium* is very efficient. The following combination recommended by Prof. Wm J. Howard, I have seen act most admirably in cardiac and renal dropsy, when all other remedies had failed to produce the desired result. namely:

R- Extr. *Hyoscyam* gr vi

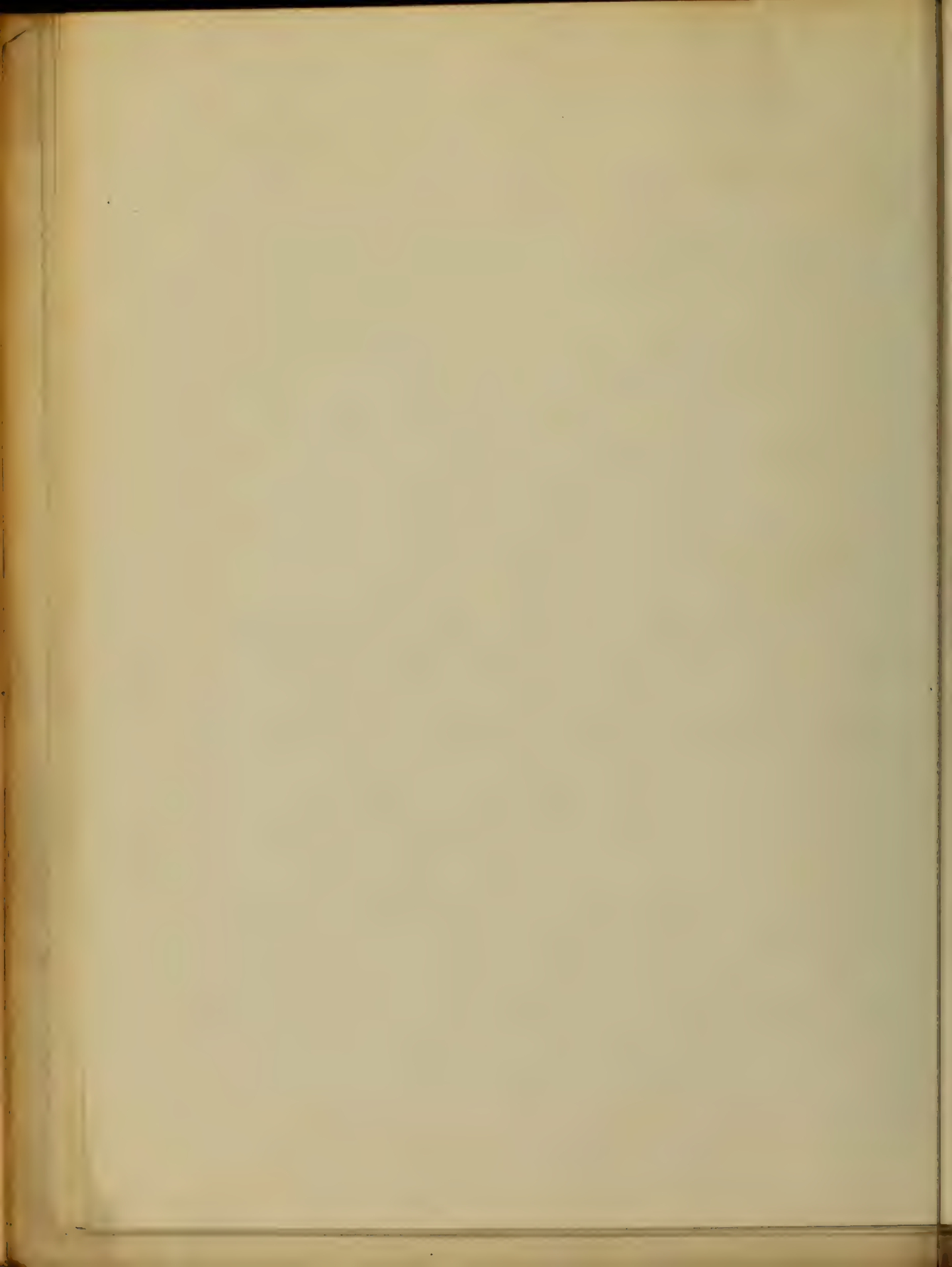
Pulv. *Capivi* gr xij

Pulv. *Elater* gr ij ℞ Pills No. 12

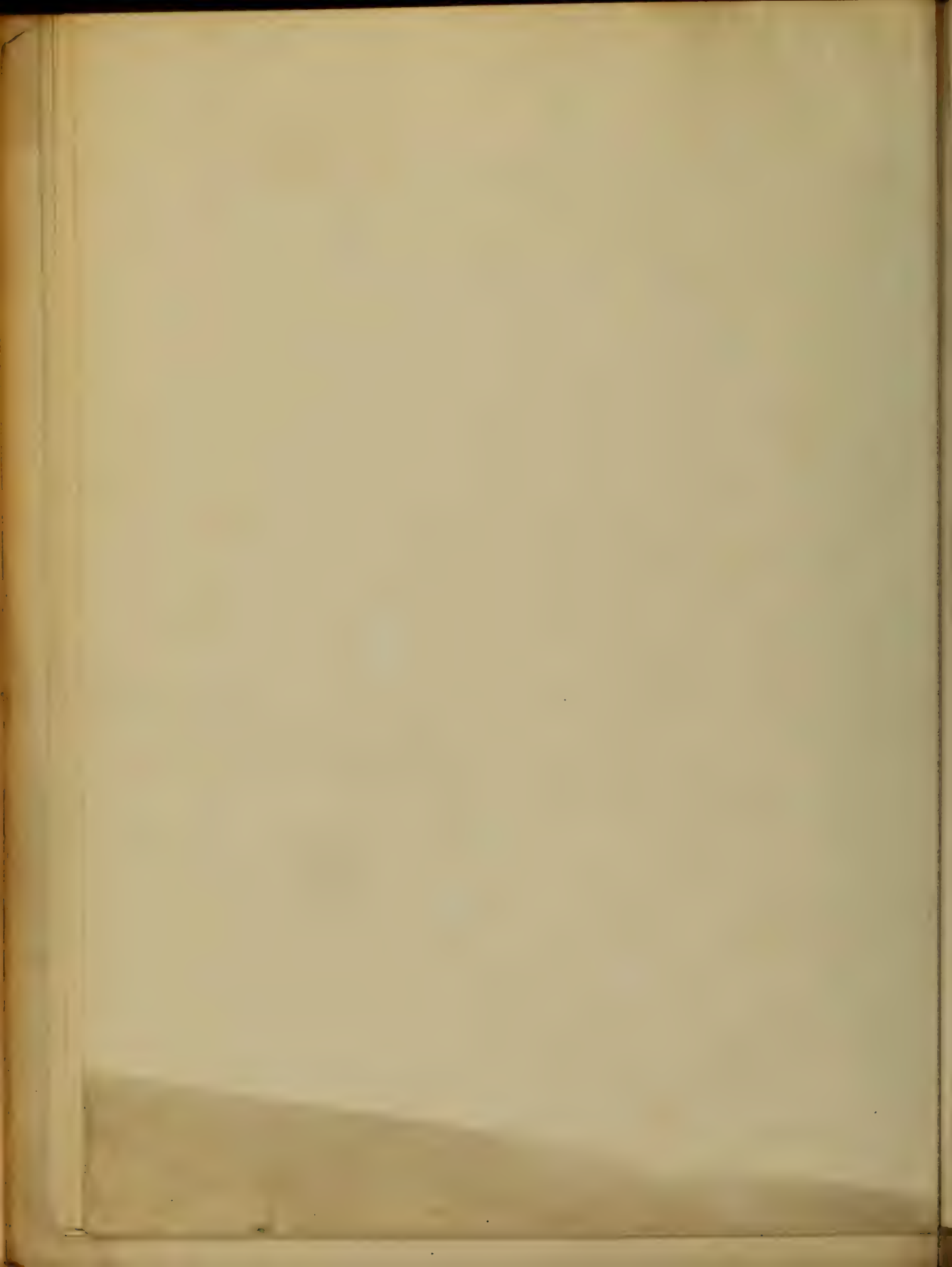
et sig. One every four hours. When too much depression follows give one three times a day.

Pulv. *Jalapal comp* is good remedy, also Bitartrate Potash, and *Podophyllum*. Should anaemia exist, *Strychnia* and *digitalis* combined are recommended by Prof. Stillé, and Iron is.

Hypertrophy not connected with valvular lesions, excessive action may be moderated by acetate,



hydrocyanic acid and belladonna. ~~Dei Polverina.~~
Plaster worn over the precordia is beneficial
in tranquilizing the action of the heart.

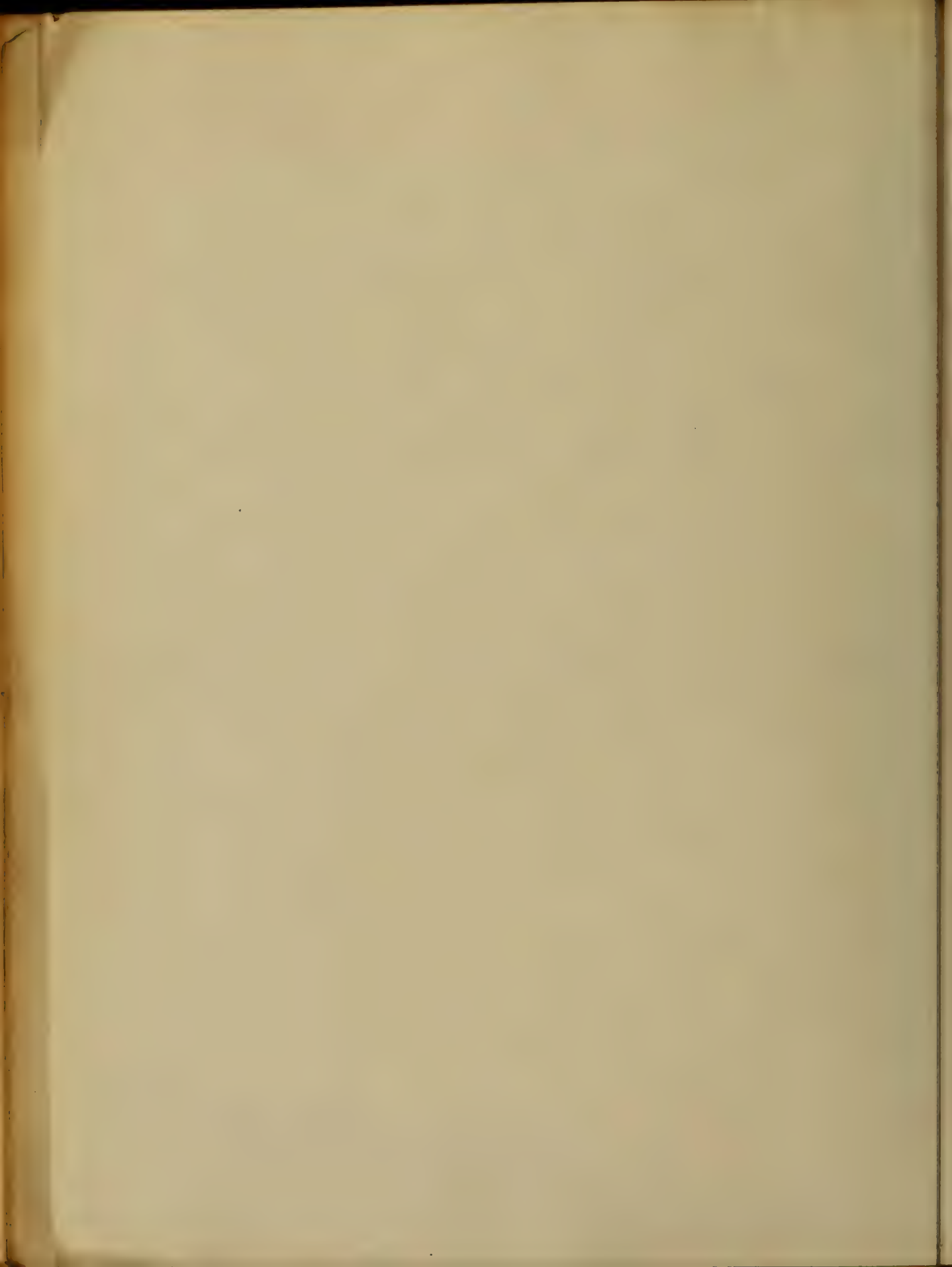


H. Davis

I hereby certify that
I have read the
of the
Maryland
Degree Doctor

G. B. Harvey

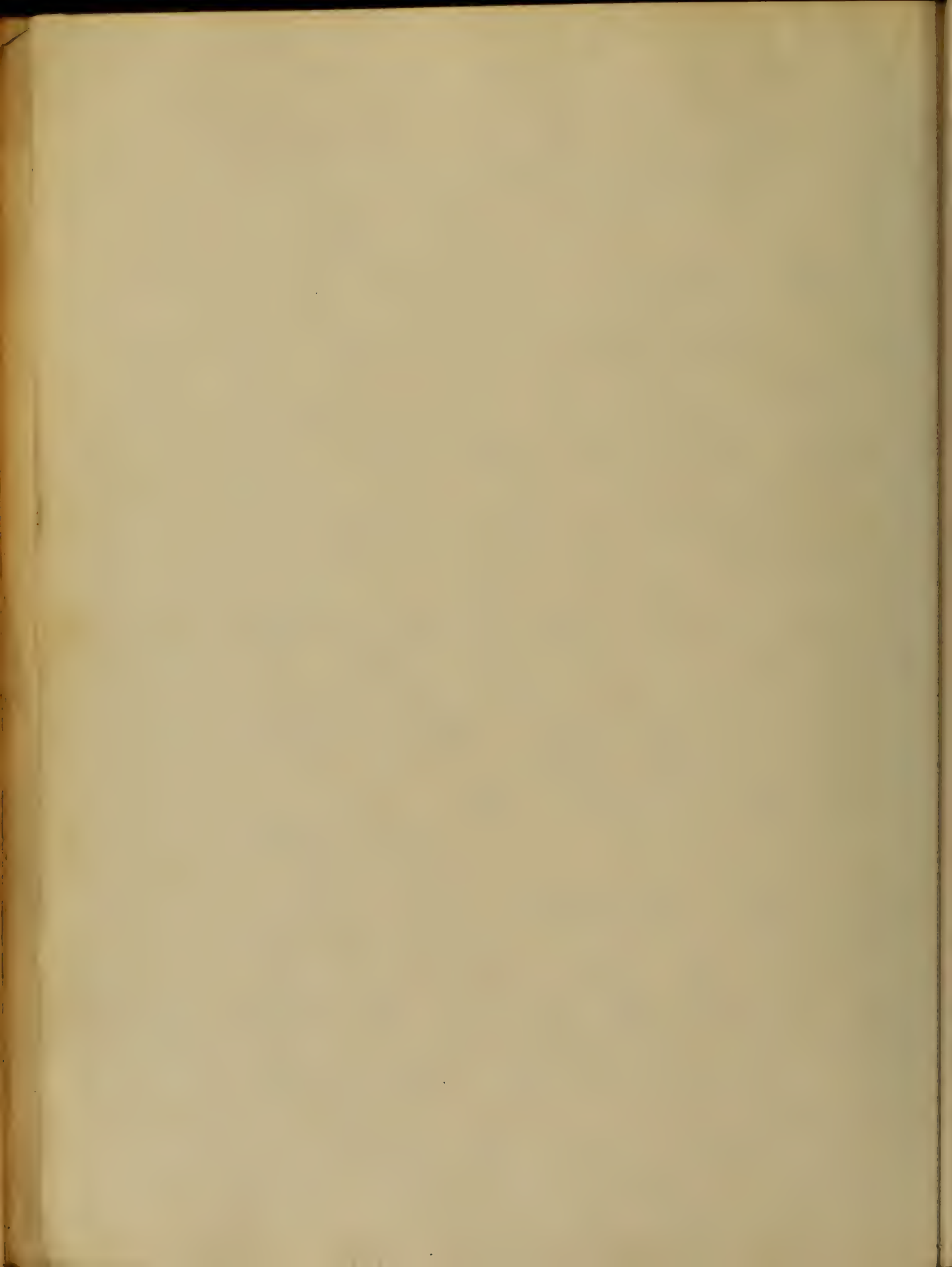
Class of 1870 '71.



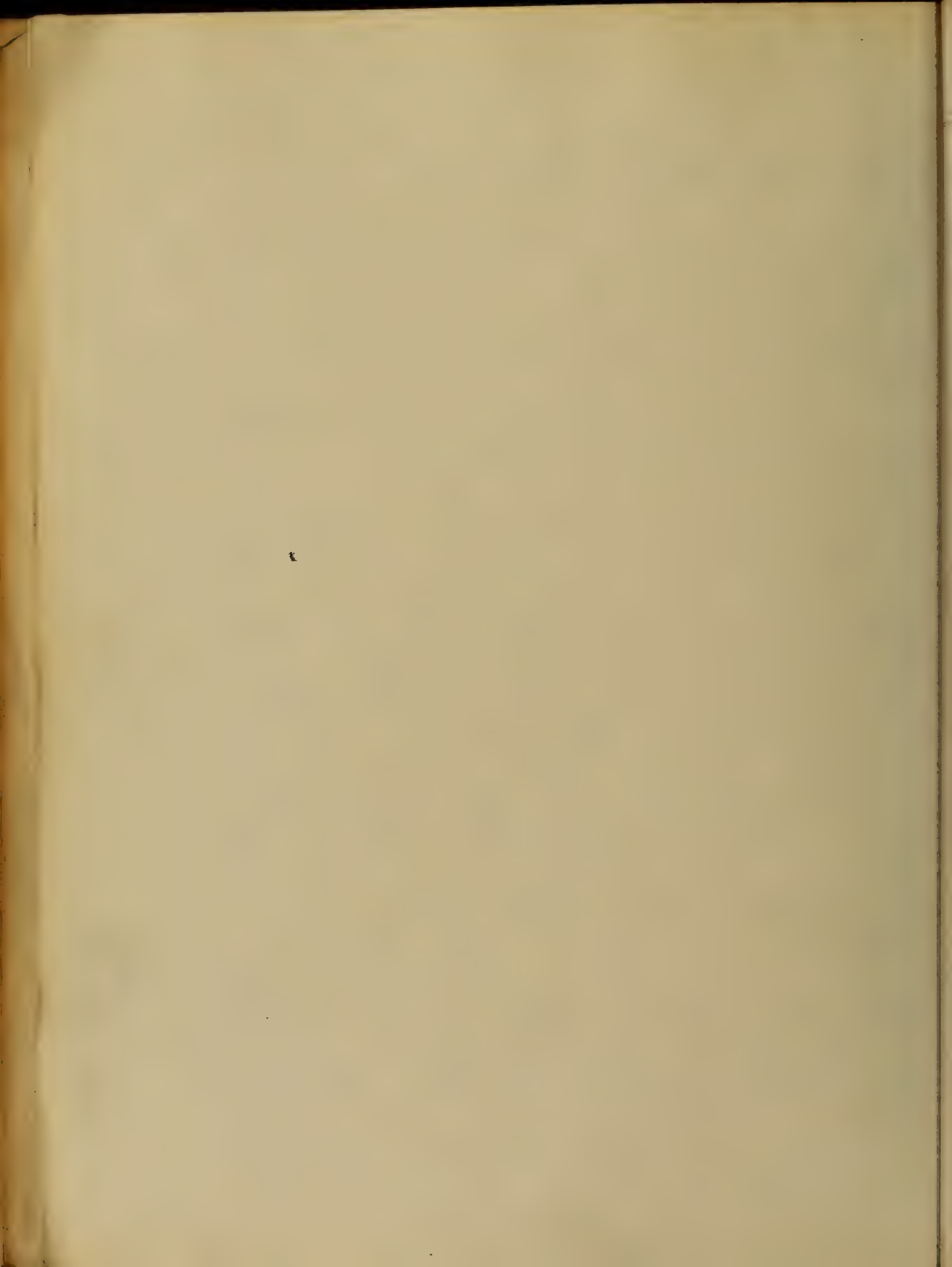
Thesis.
Typhoid Fever.

In token
of the high respect for
his superior mental
culture, and his assid-
uous labors in striving
to advance his class
in the narrow road
of sound pathology and
practice, do I respect-
fully dedicate this thesis
to Prof. McSherry.

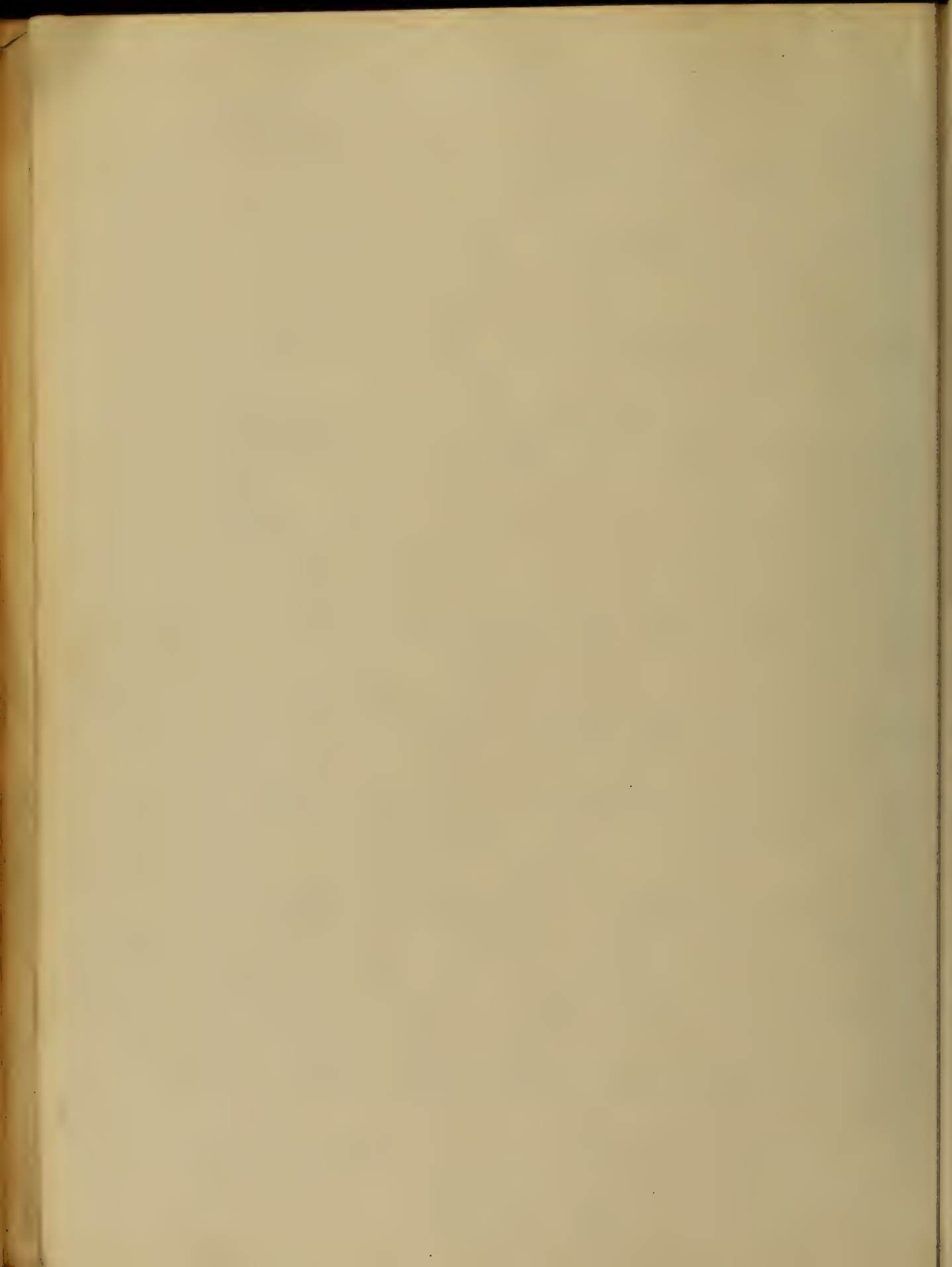
In select-
ing this disease as the
subject of my thesis, I do
not want to convey the idea
that I am better acquainted



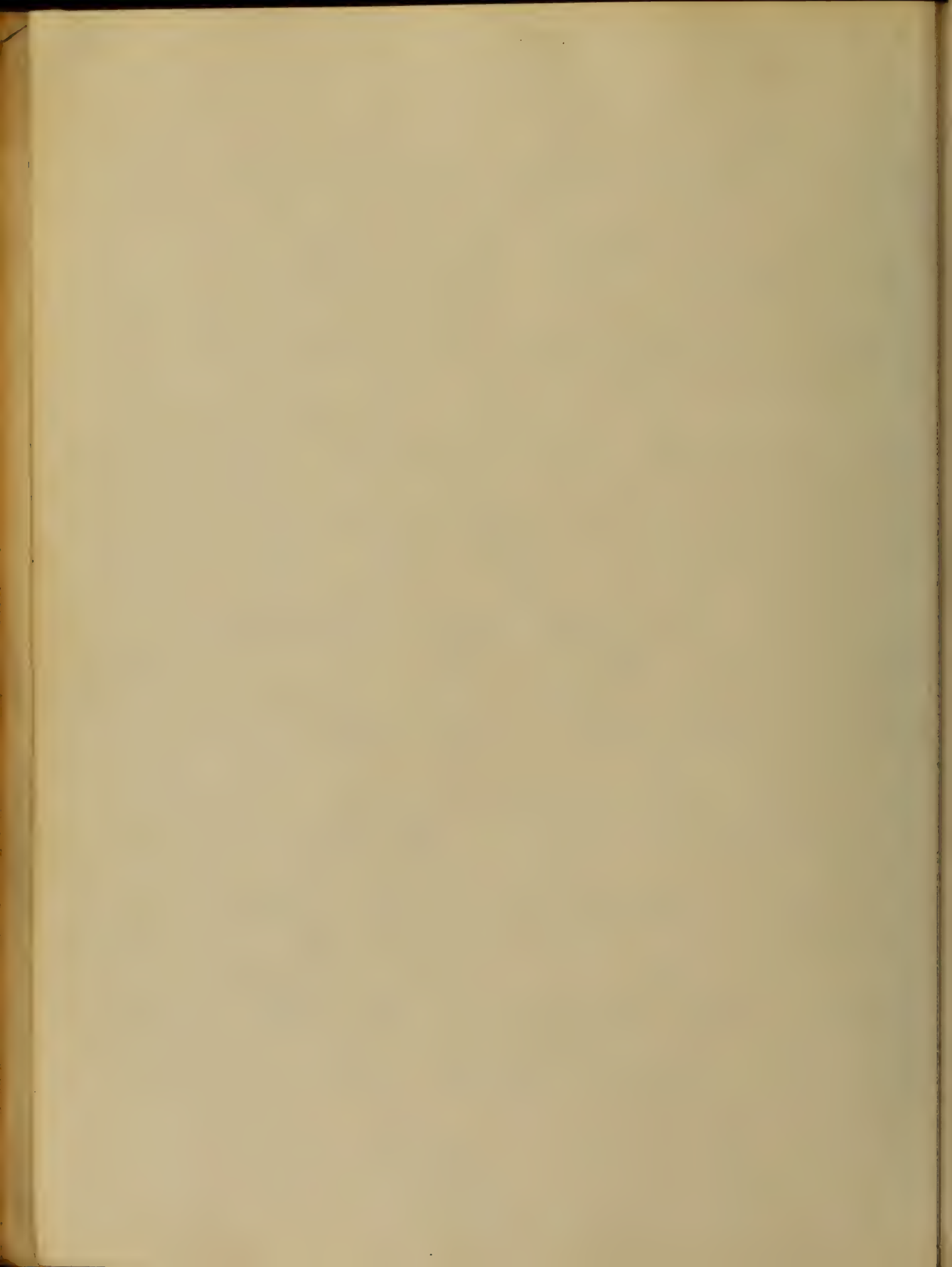
with it than any other of the numerous maladies to which the general practitioner will be called to treat; but as it is the most dangerous, as well as prevalent, disease in my section of the country, I thought it expedient to know and understand it as well as possible for a student to know any disease from theory. In treating this subject, it will be necessary for me to adopt the plan of describing diseases used by some authors in Practice, as I do not



consider competent or
ingenious enough to devise
any other method that
would answer her as
well, consequently I will
follow the method of Prof.
"Austin Flint" in his able
and valuable work on
the "Practice of Medicine",
inserting, at the same
time, material from my
valuable notes, taken from
the lectures on Practice
which have lighted my
path during this session.
Typhoid is one of the
essential, or Idiopathic



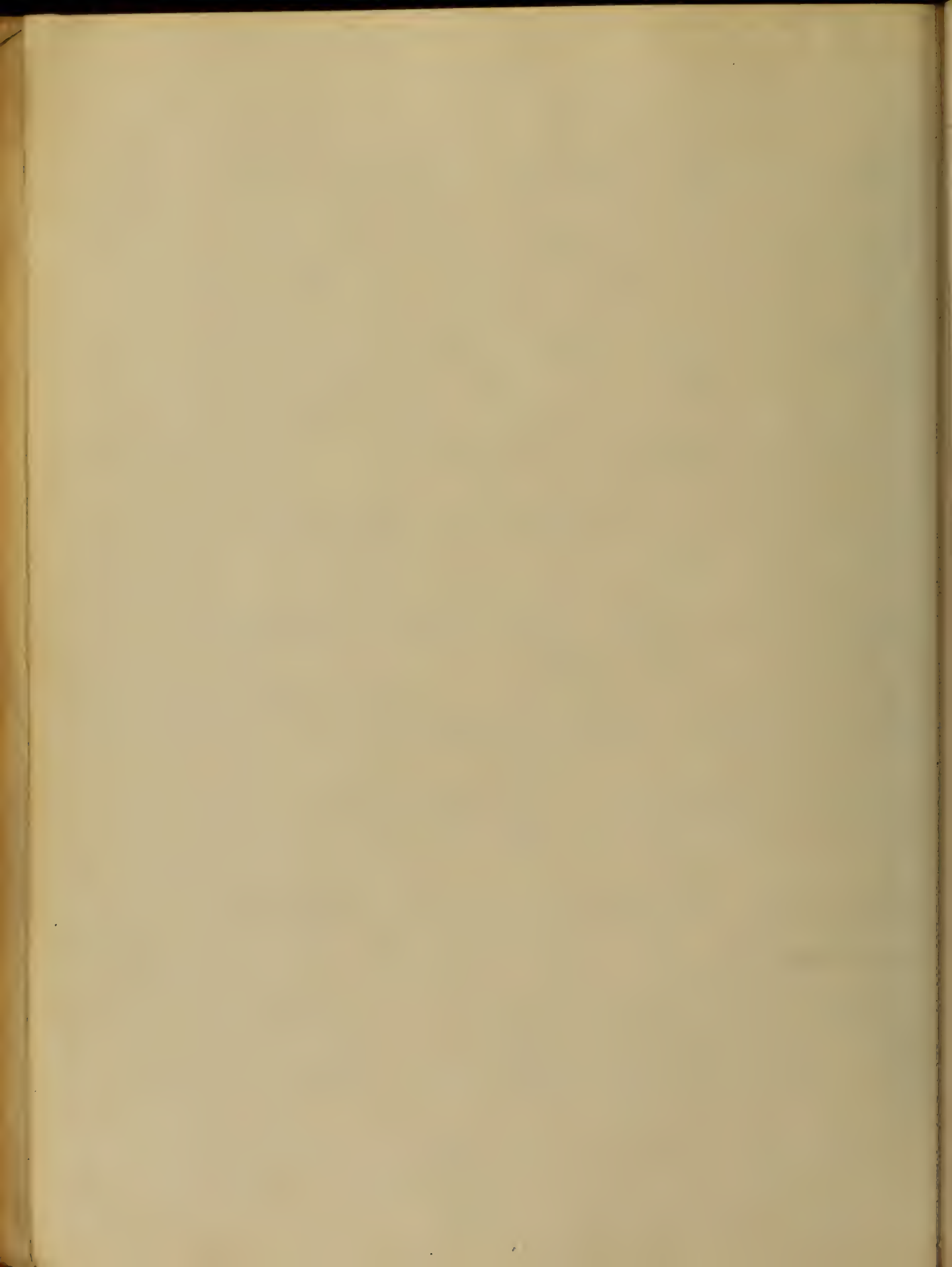
fears; and I suppose it
would be well for me
to define an idiopathic
from a symptomatic
fever, as I wish to make
the subject as rapid as
possible. An essential fe-
ver is one of the ele-
mentary forms of disease,
that is there are no
other lesions in the e-
conomy to which the
symptoms can be refer-
red. A symptomatic fever
is one of the secondary
forms of disease, or the
febrile symptoms are



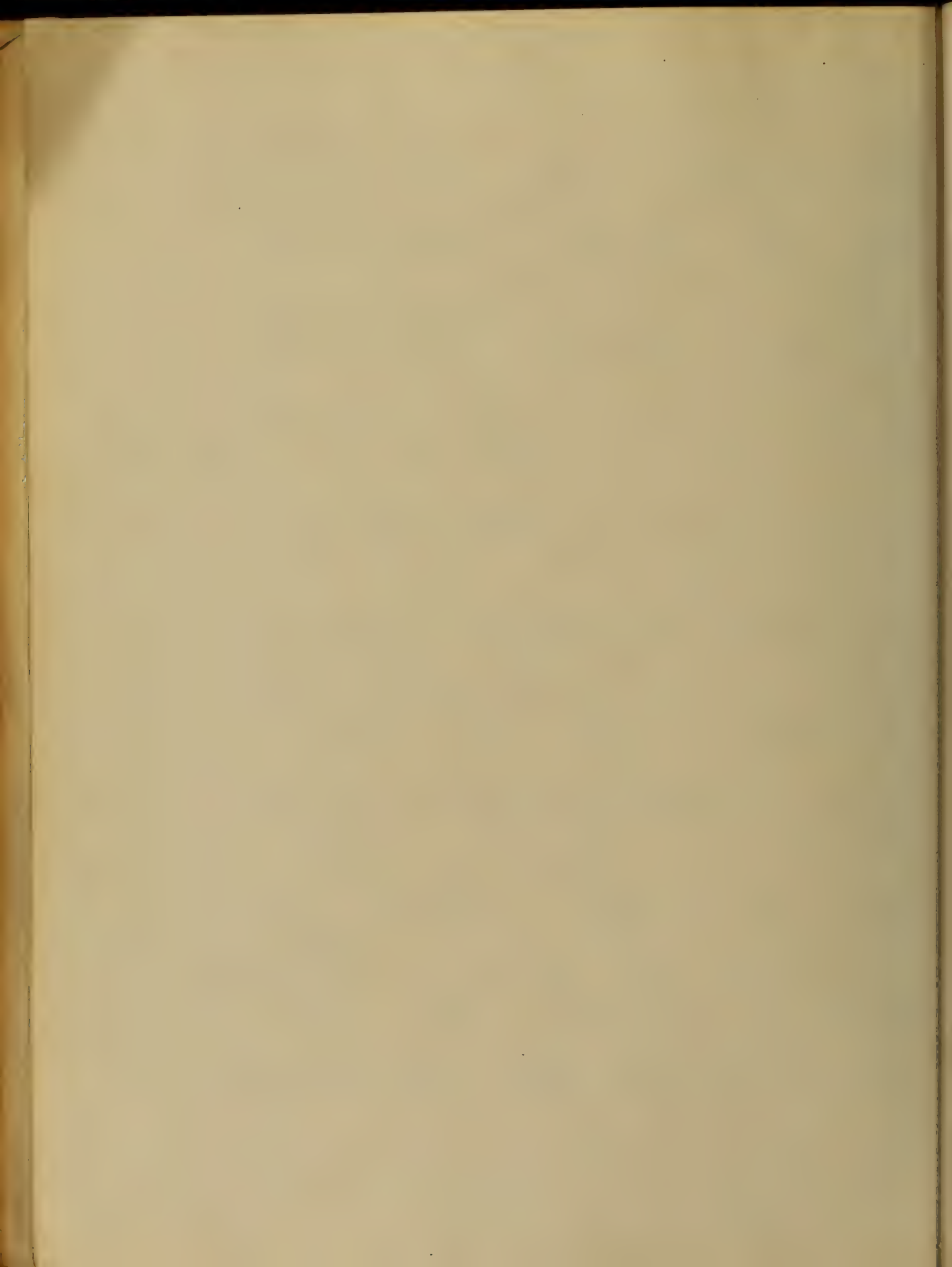
caused by some local inflammation of some organ of the body, which cause is the primary lesion. The word Typhoid means Typhus-like, or resembling Typhus. Typhoid is a continued fever characterized by rose colored spots, diarrhea, and abdominal symptoms.

Anatomical Characters —

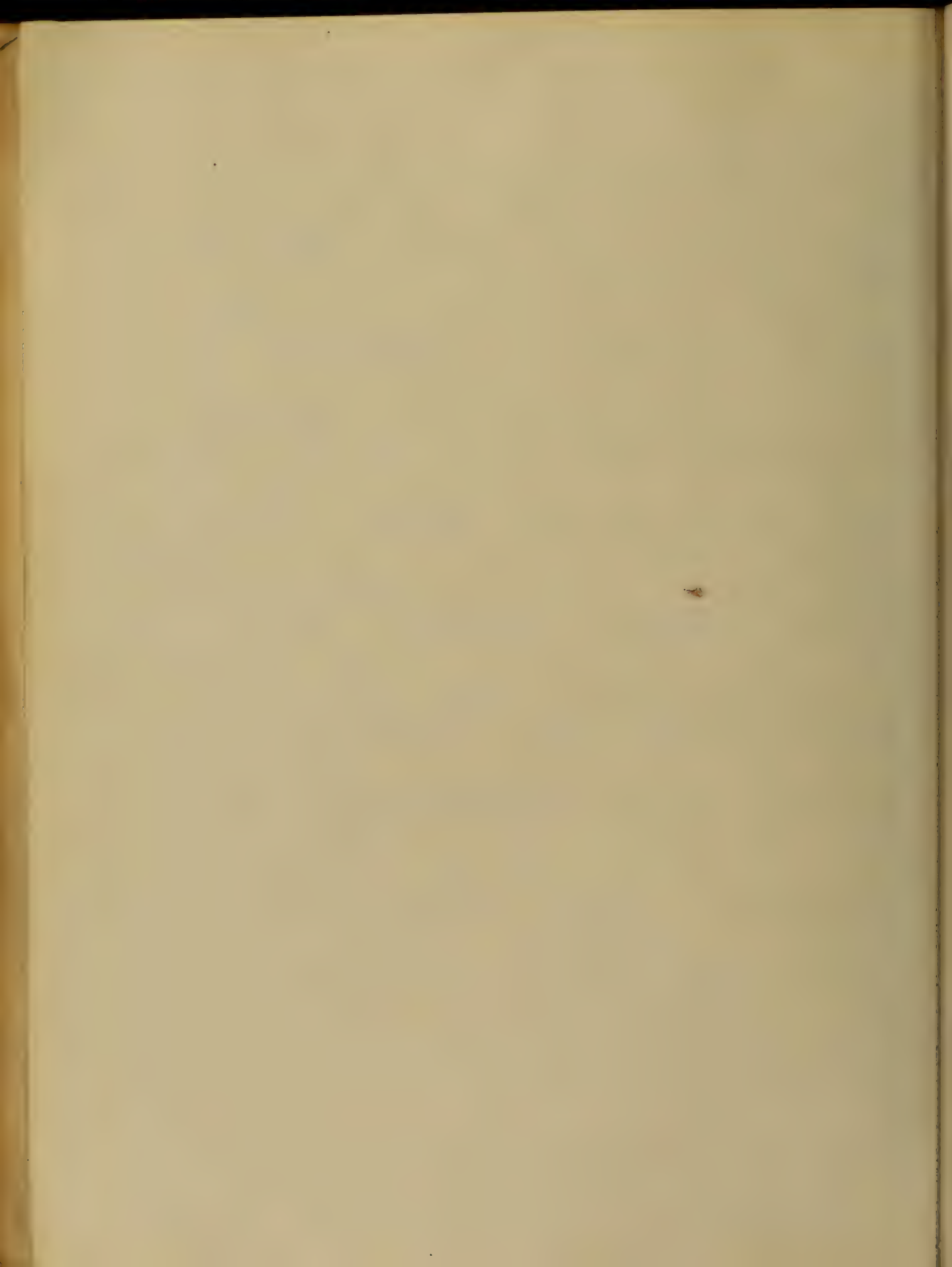
This disease has several lesions which are highly characteristic and important for the practitioner to understand. These lesions



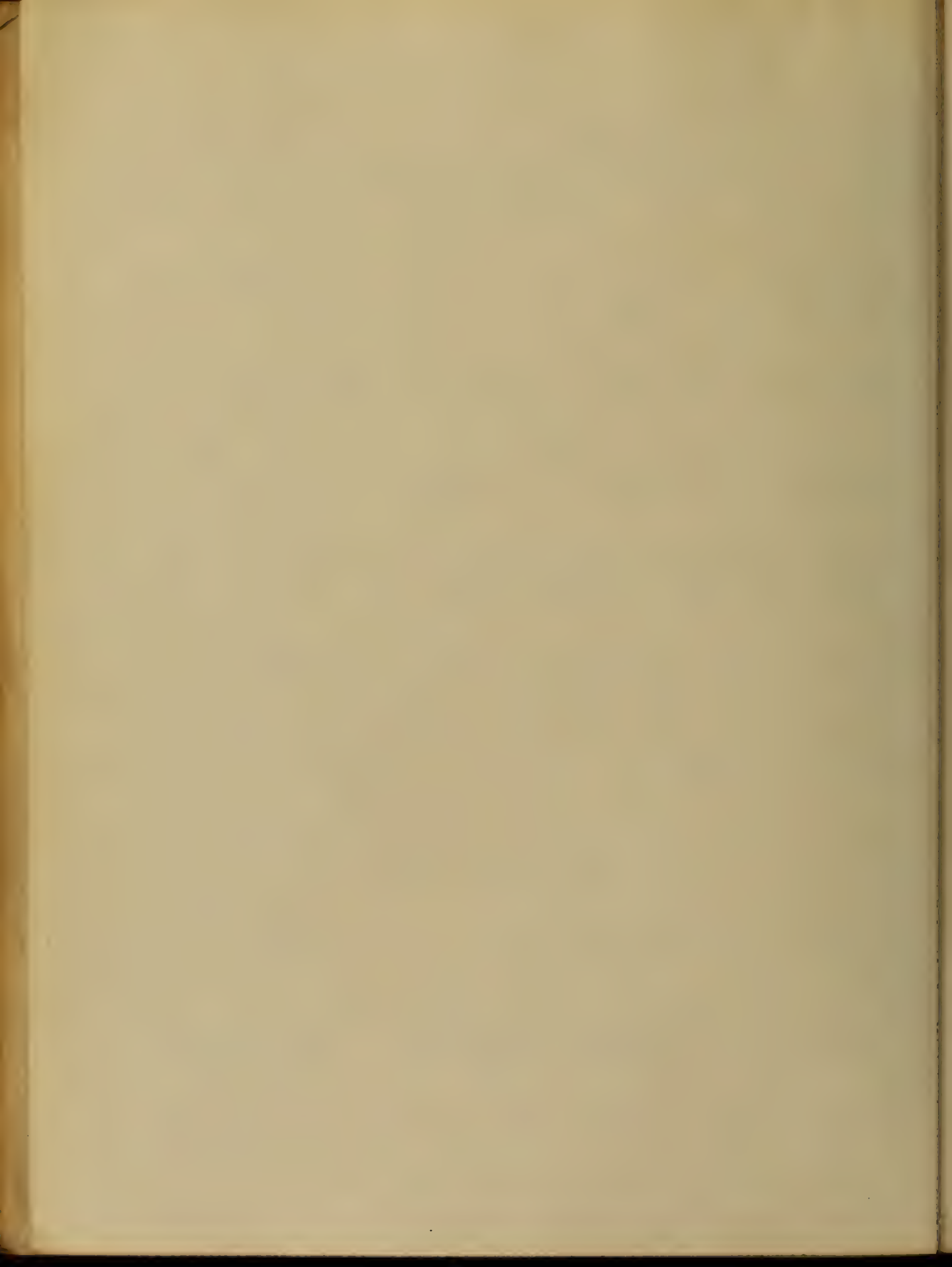
are seated in the glands
of the small intestines,
and are pathognomonic
of this disease. First, the
glands are congested and
enlarged at the same
time; second, sloughing
away of the glands and
the deposit; third, ulcer-
ation; fourth, cicatrization.
It should be remembered
that cicatrization never
leads to stricture of
the gut. The ulcers are
distinguished from tuber-
culous ulcers by the
overlapping of the mucous



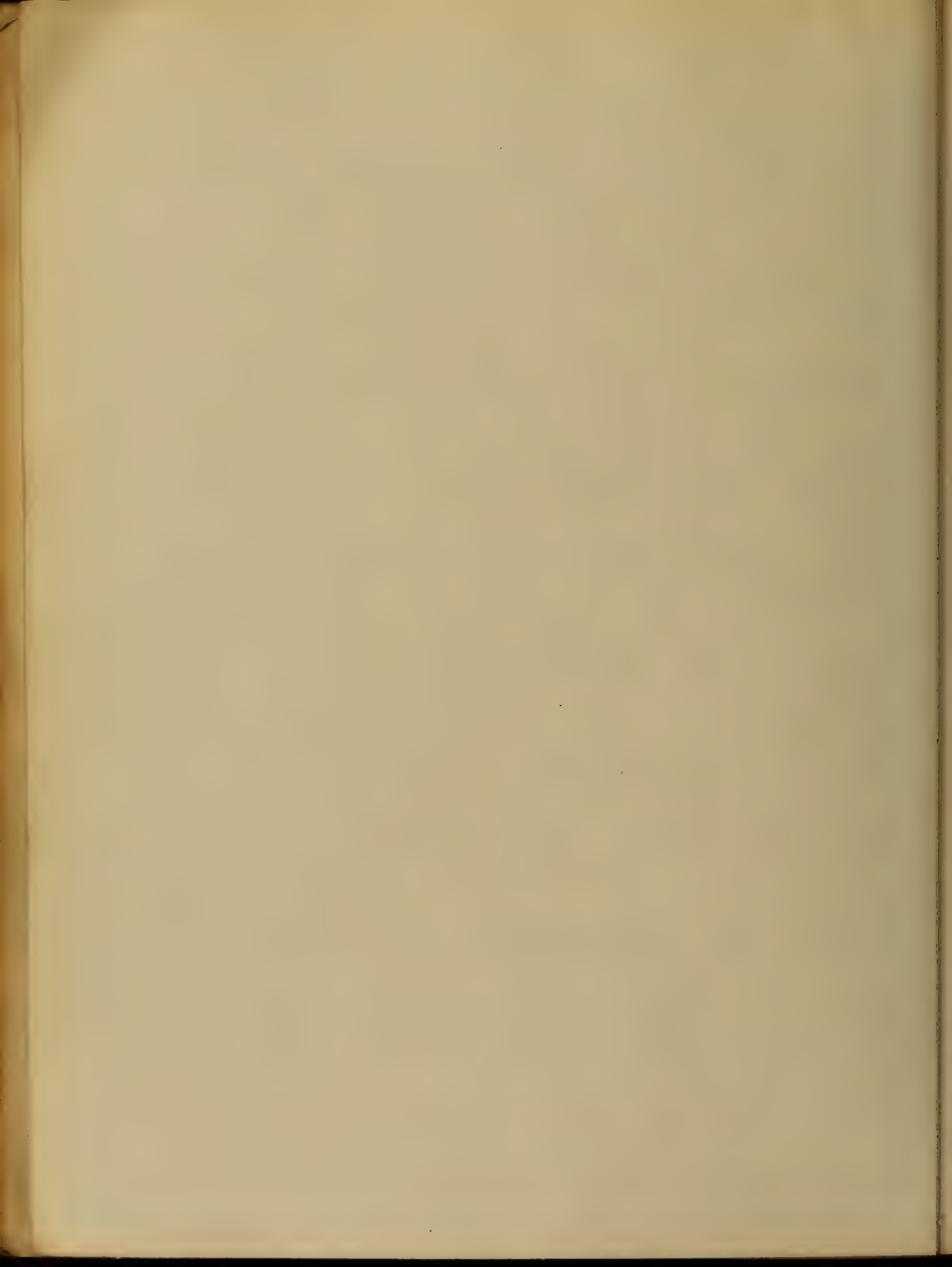
membrane, and are not
hardened at the edges.
The glands nearest the cae-
cum are first affected
and the ulceration proceeds
upwards, those highest in
the intestinal tract being
last to become ulcerated.
These ulcers may lead
to perforation of the in-
testines. The mesenteric
glands are enlarged at
the same time. These
lesions are character-
istic of this disease
and occur in no
other.



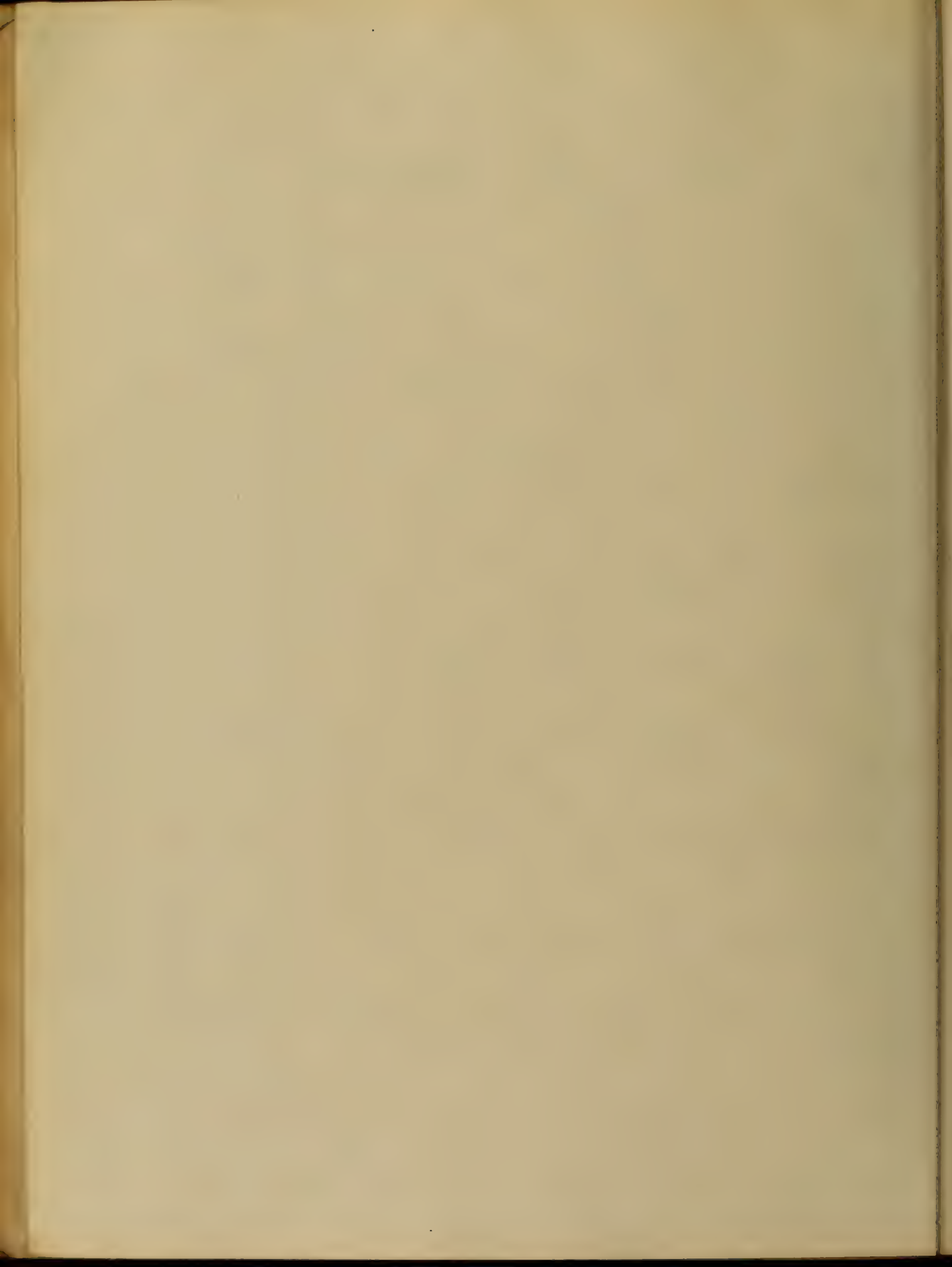
Clinical History— This fever is developed gradually, and may take several days in this prodromic stage. It is sometimes hard to establish the exact date of commencement; but generally, the time is recalled from the patient's taking to bed, after which the stages are recalled by weeks; as, first, second, and third. The symptoms belonging to the prodromic stage are chills, cephalgia, mental



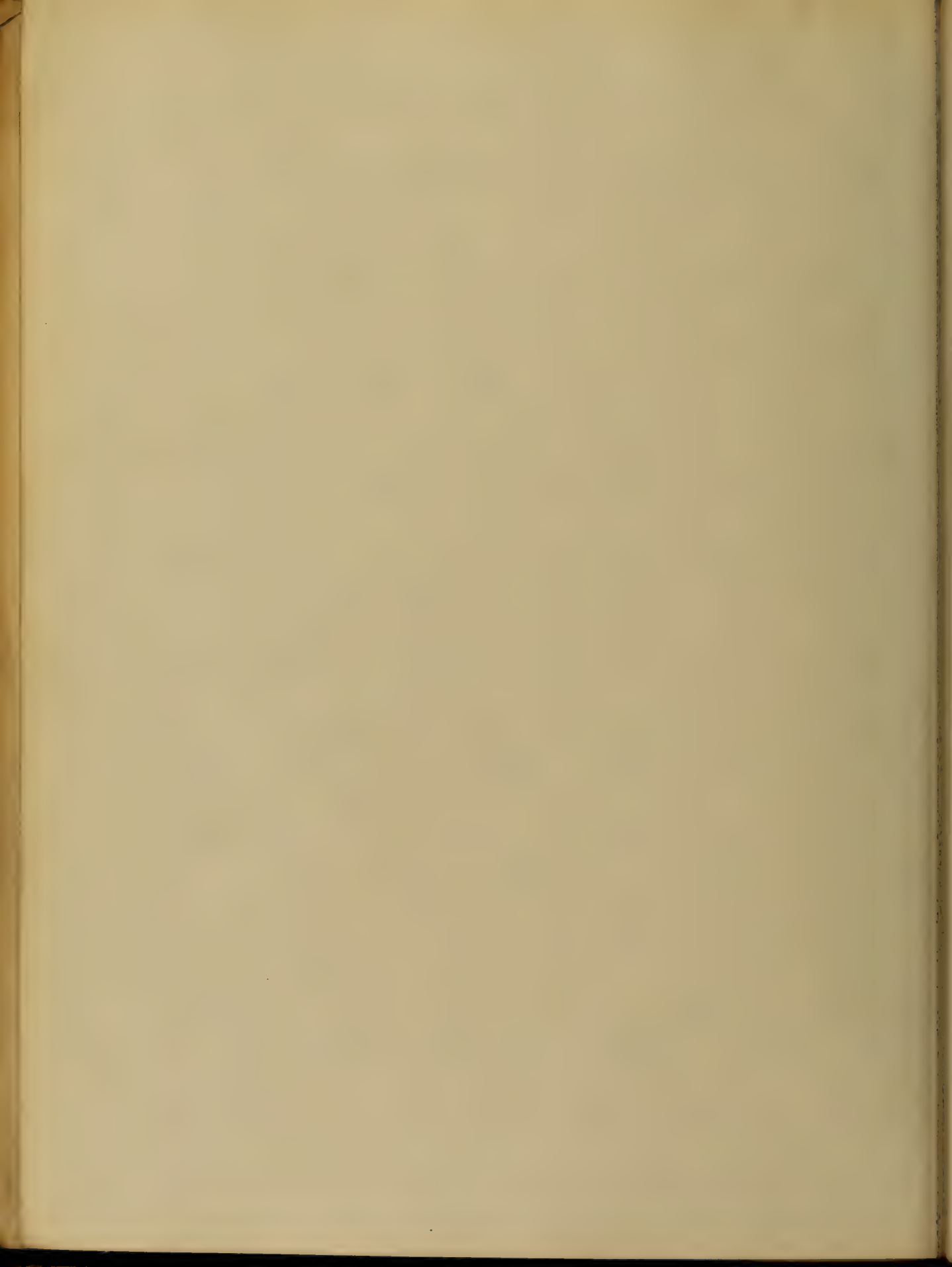
irritability, epistaxis, pain
in the limbs, and loose-
ness of the bowels. After
this there is a marked
change in the counte-
nance. The face is red
and flushed, and presents
the appearance of stu-
pidity. Gurgling sounds
may be produced by
pressure on the abdomen.
The temperature increases
regularly for about a
week and does not
rise suddenly as in
some other forms of
fever. During the sec-



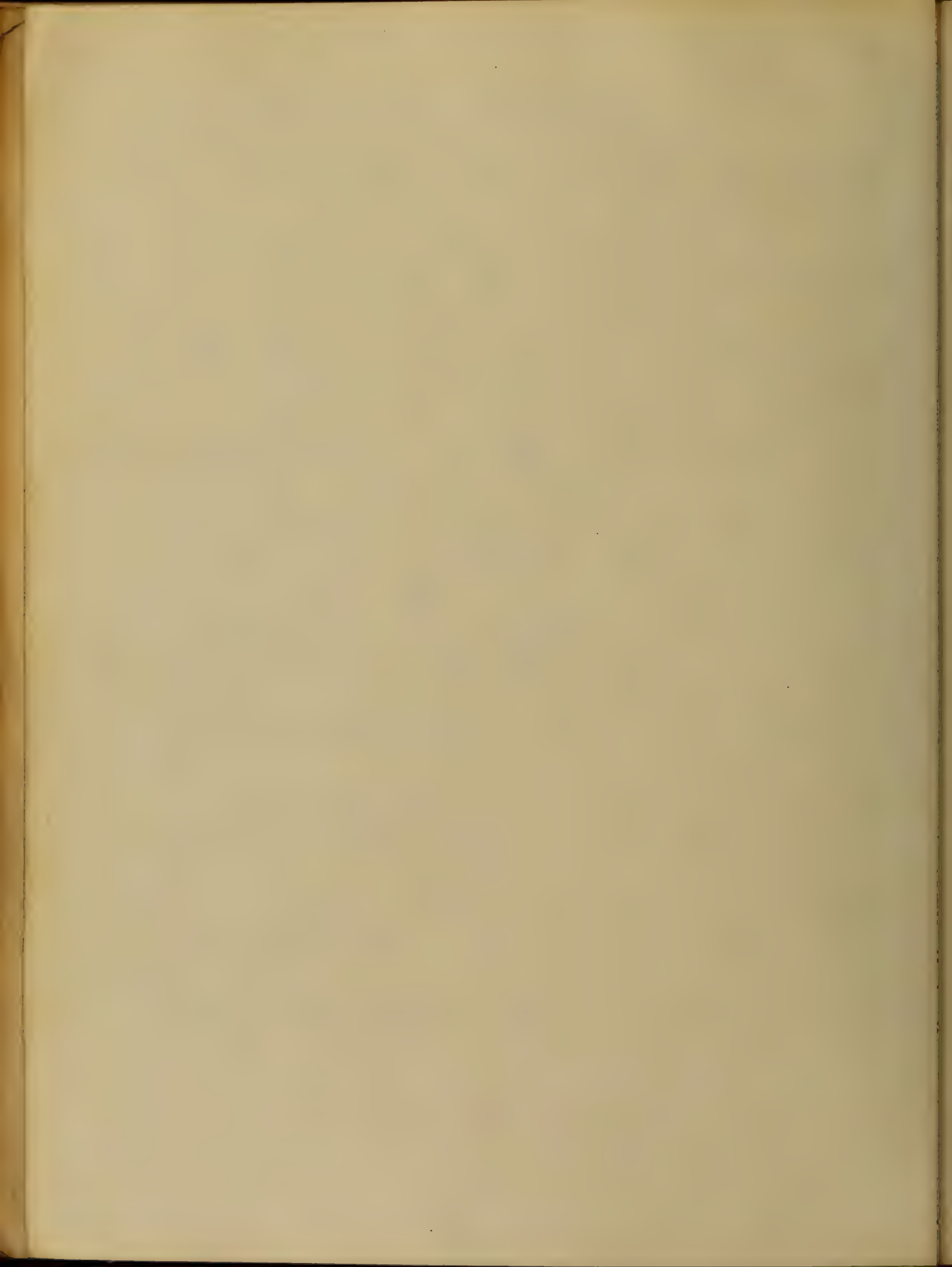
and when the papulae appear; they occur in about three fourths of one of the cases. The sense of hearing is somewhat obtunded. The tongue is protruded with difficulty, and is tremulous; sometimes the patient seems to forget to draw it back, showing a loss of mental concentration. *Subsultus tendinum* is sometimes present and is often observed at the wrist than in any other situation.



The disease commonly lasts three or four weeks, and as a rule takes a change for better or worse on or about the thirty first day - this is called the critical day by some authors. The increase of the pulse of eight or ten beats per minute should indicate a corresponding rise of temperature of at least one degree. The pulse ranges from one hundred to one hundred and twenty. The specific

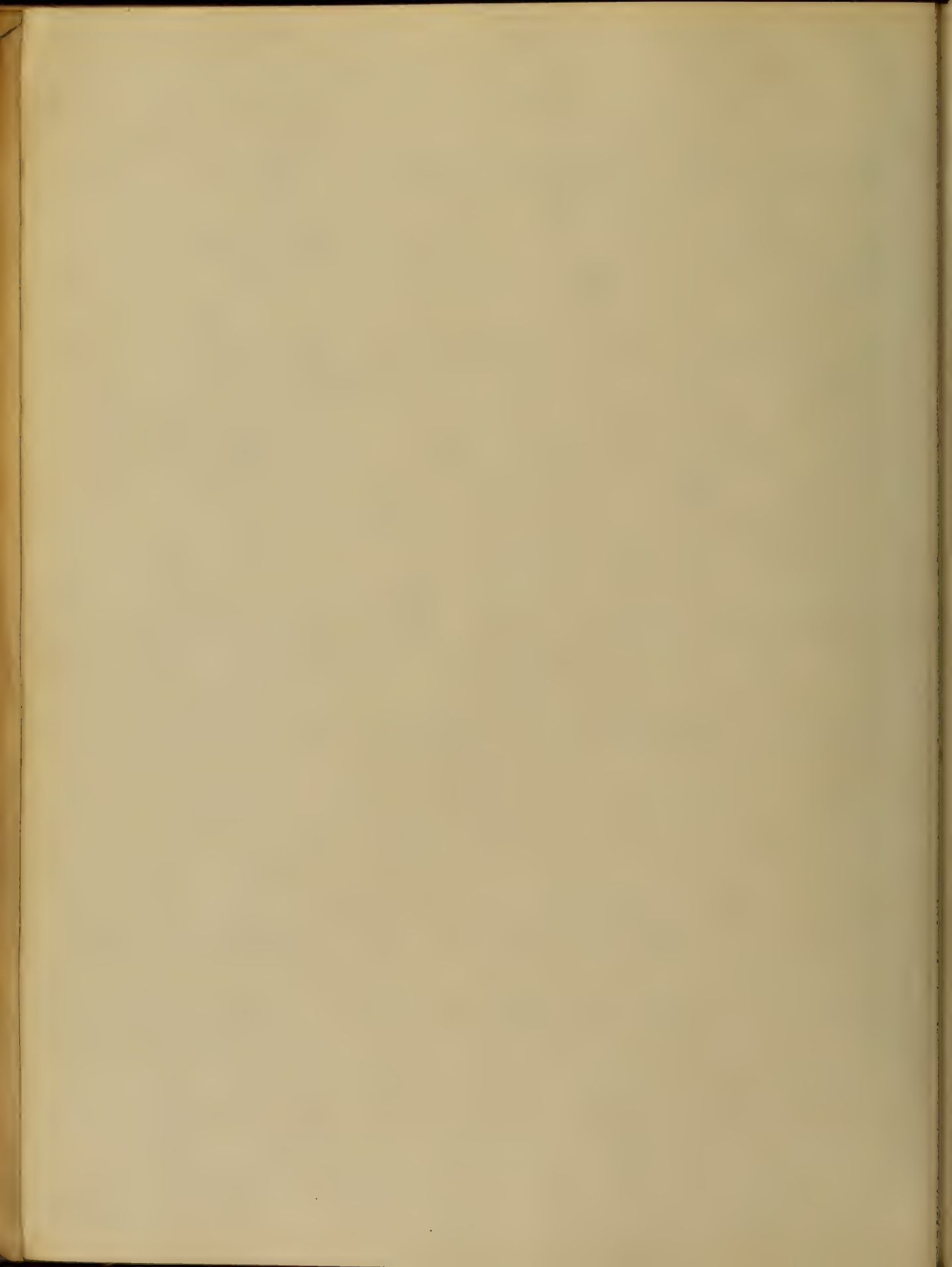


gravity of the disease
is increased, and death
on account of contain-
ing more urea. In some
stages of the disease
the urine may contain
albumen. Hemorrhage from
the bowels occur in a
proportion of the cases,
and may be so abun-
dant as to cause death.
This disease rarely
occurs in person over
fifty years of age.
The disease is mostly
spontaneous in its origin,
but may in some



cases be propagated by contagion. The contagious material by which the disease is conveyed to other persons is believed by many to be in the feces. The stools are rather colored.

Diagnosis — This fever is to be differentiated from Typhus and remittent fevers. This is not always easy to do in the beginning of its career, but as the disease advances the diagnosis is easily made.

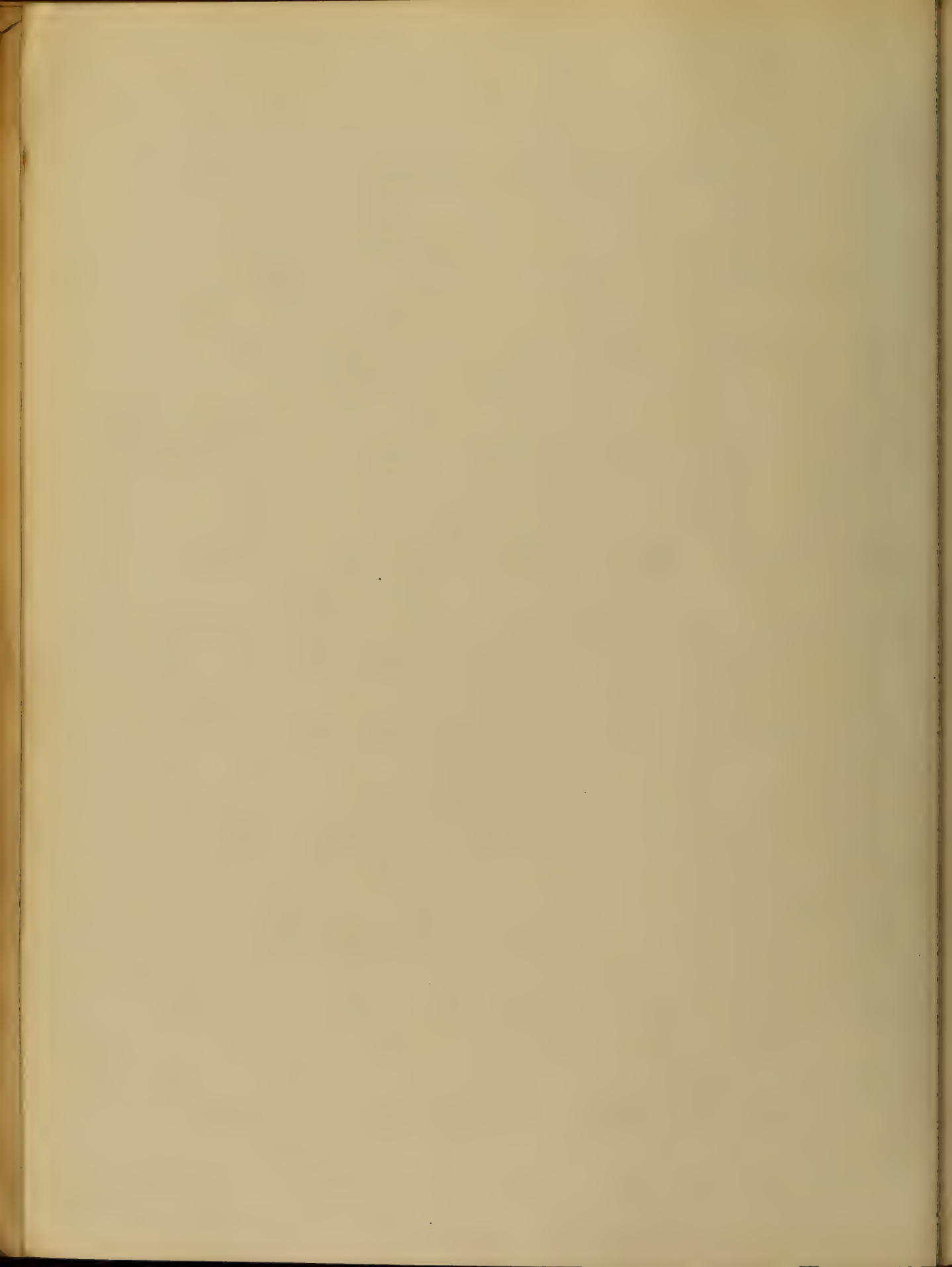


First, you will take into consideration the period occupied by the post-typhoid stage, which is longer in this fever than in any of the other two named above.

Second, the diarrhoea, ochre-colored stools, with the abdominal symptoms which as before mentioned are pathognomonic.

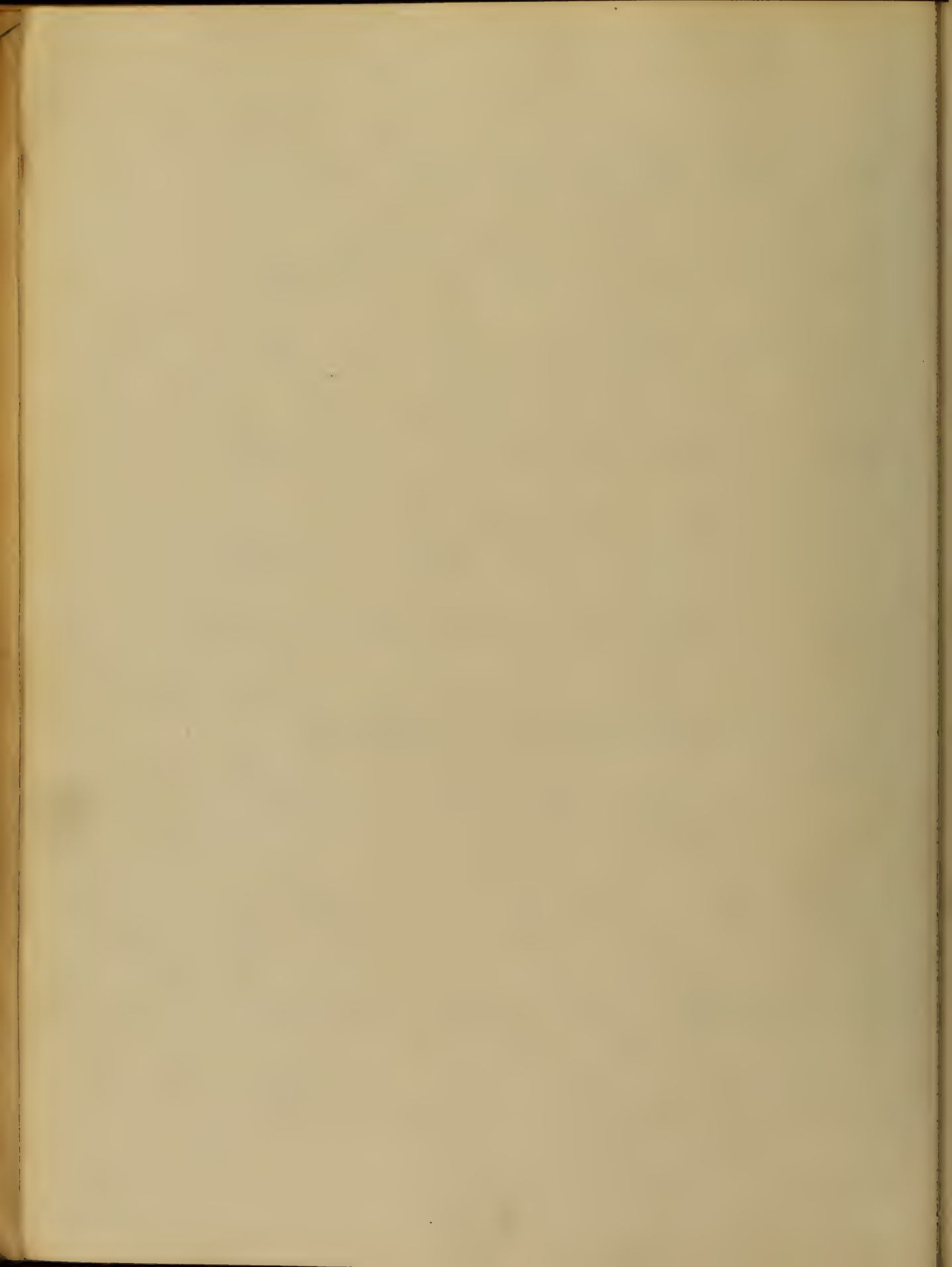
Third, the occurrence of epistaxis, and the appearance of the eruption.

Fourth, the age of the patient, and the sea-



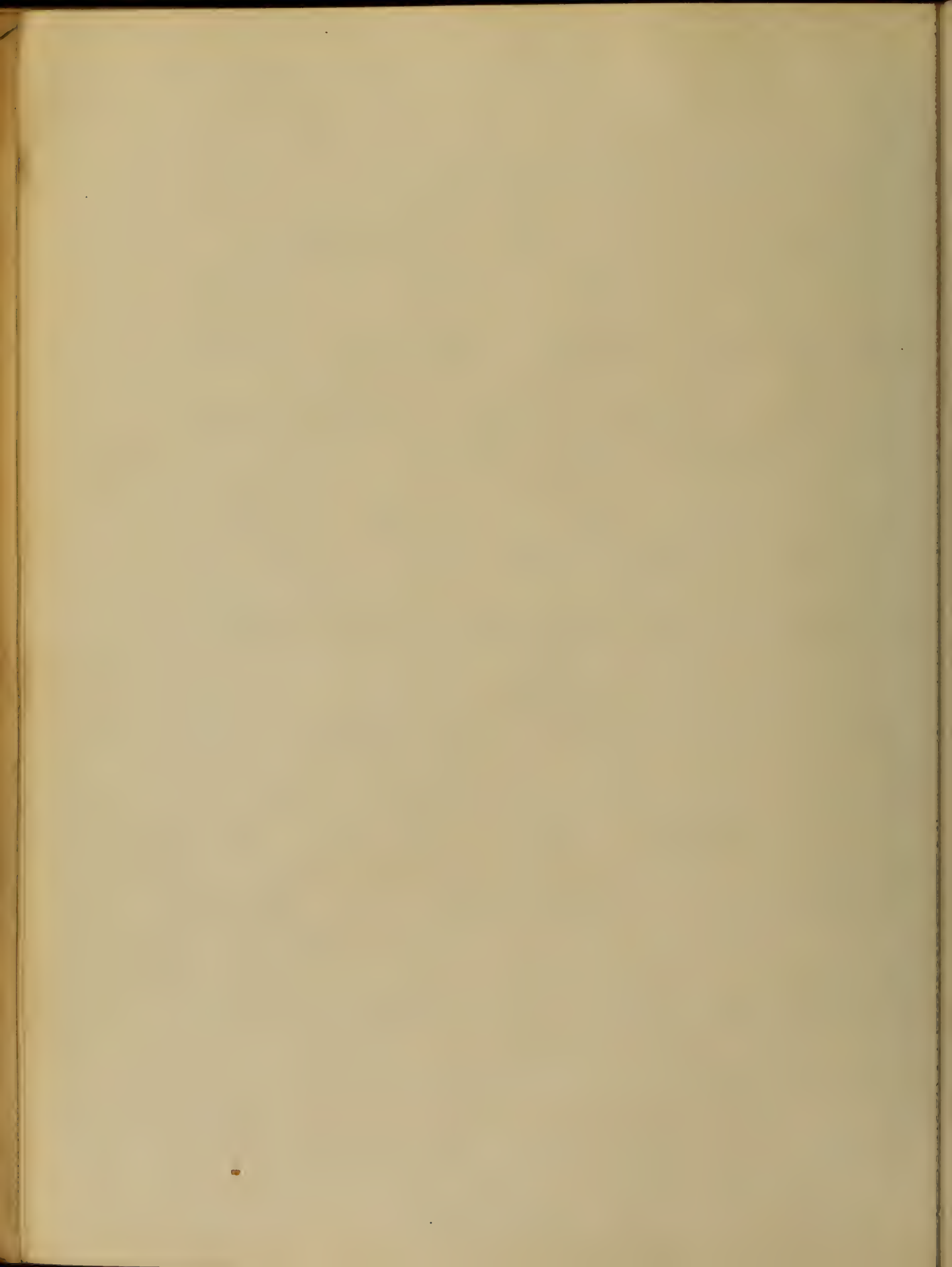
son of the year in which the disease is most prevalent. To diagnose from any of the symptomatic fevers, you determine whether there are any lesions in any of the internal organs which would bring about any such constitutional effects.

The above points fully considered and recognized will render the diagnosis easy, especially if the practitioner has had any



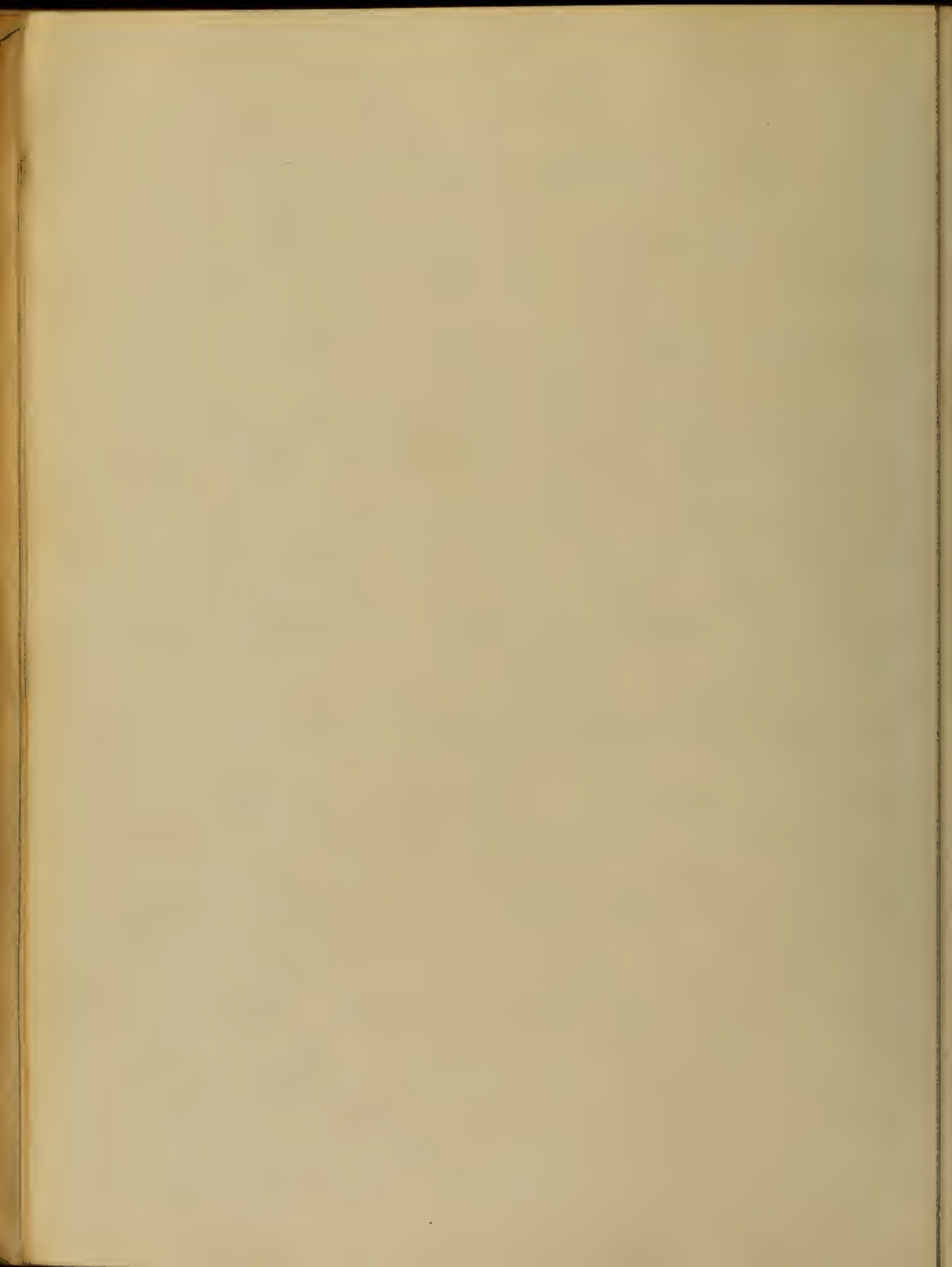
clinical experience.

Prognosis— The statistics as given by most writers show a very large mortality, ranging from fifteen to twenty per cent of all of the cases taken into account. Though different epidemics show a marked difference in this in this respect, however it is enough to say that the disease is extremely dangerous. Death is rarely due to the disease per se; but is generally attributable



to some of the many complications which the disease is liable to take on; viz, Pneumonitis, Pleuritis from perforation, or from the severity of the abdominal symptoms.

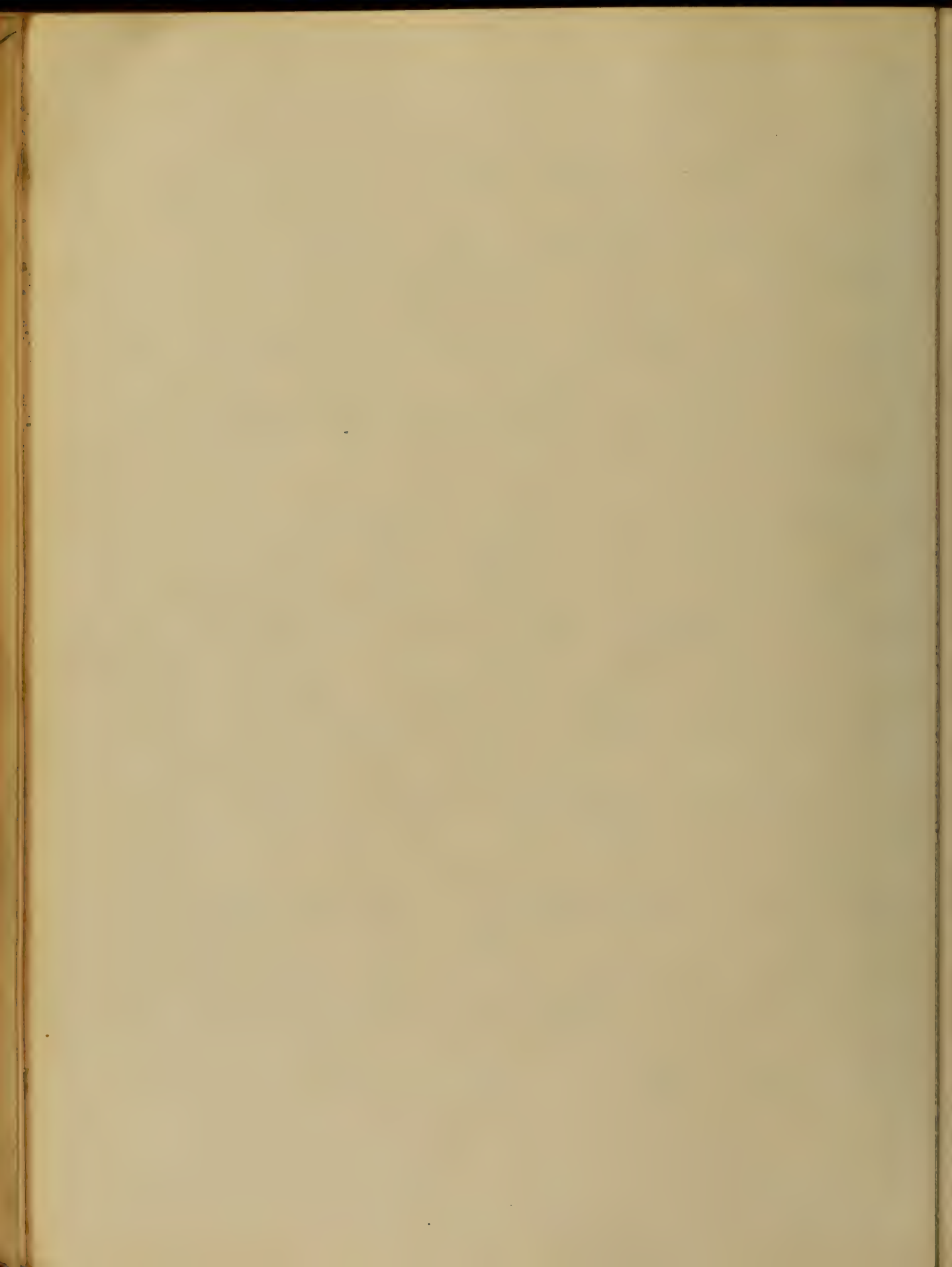
Weakness, and great frequency of the pulse denote the near approach of death. Carphologia is another very unfavorable symptom. Hemorrhage from the bowels, is not considered by Dr. Flint to be an unfavorable one, but many writers differ



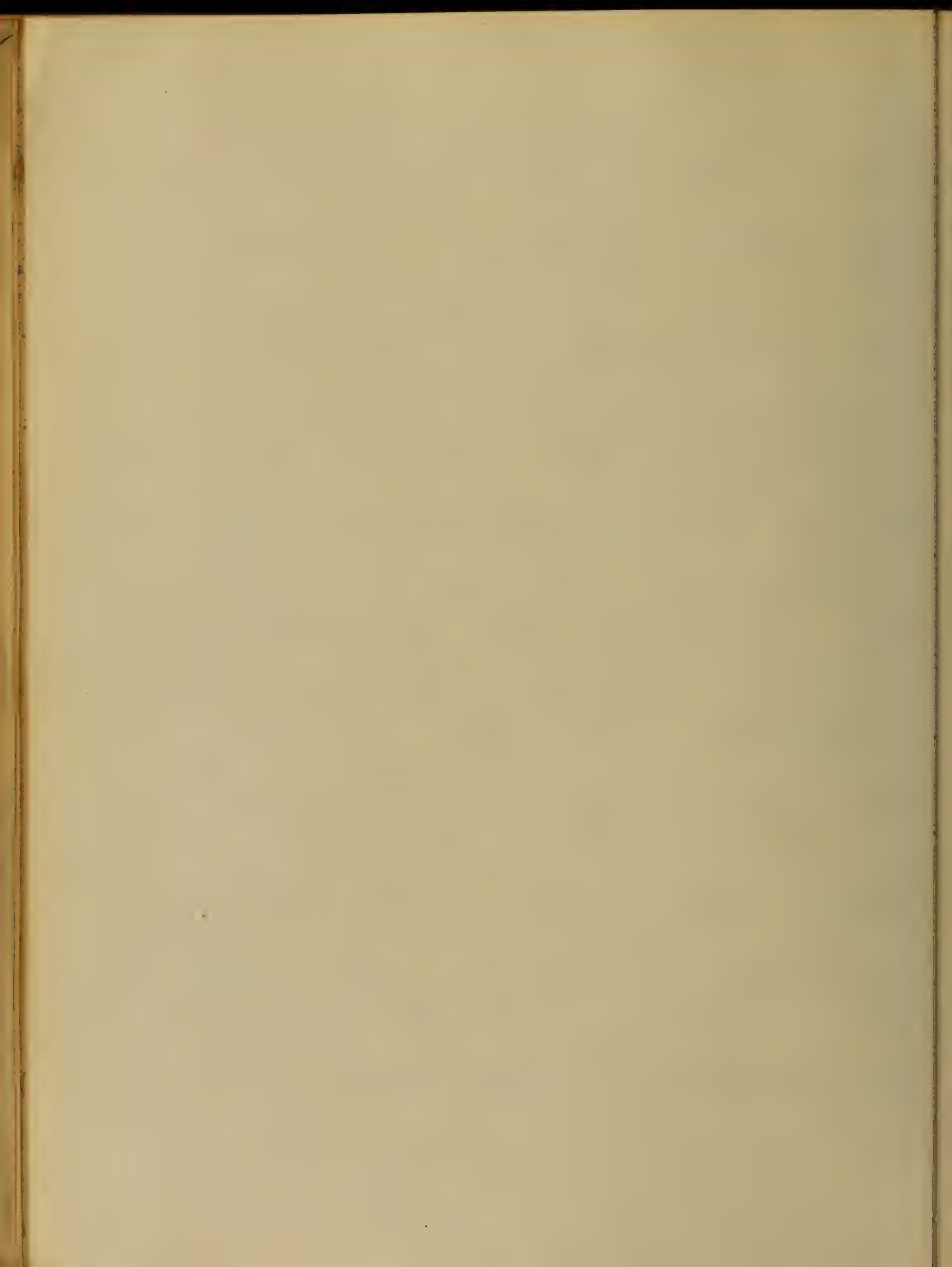
from him. I have only
seen two cases of this
disease - in both profuse
hemorrhage occurred, and
both cases terminated fu-
tally.

Treatment - It must be
remembered at the beginning
that there are no known
remedies by which this
disease can be abridged
or cut short of its
regular termination.

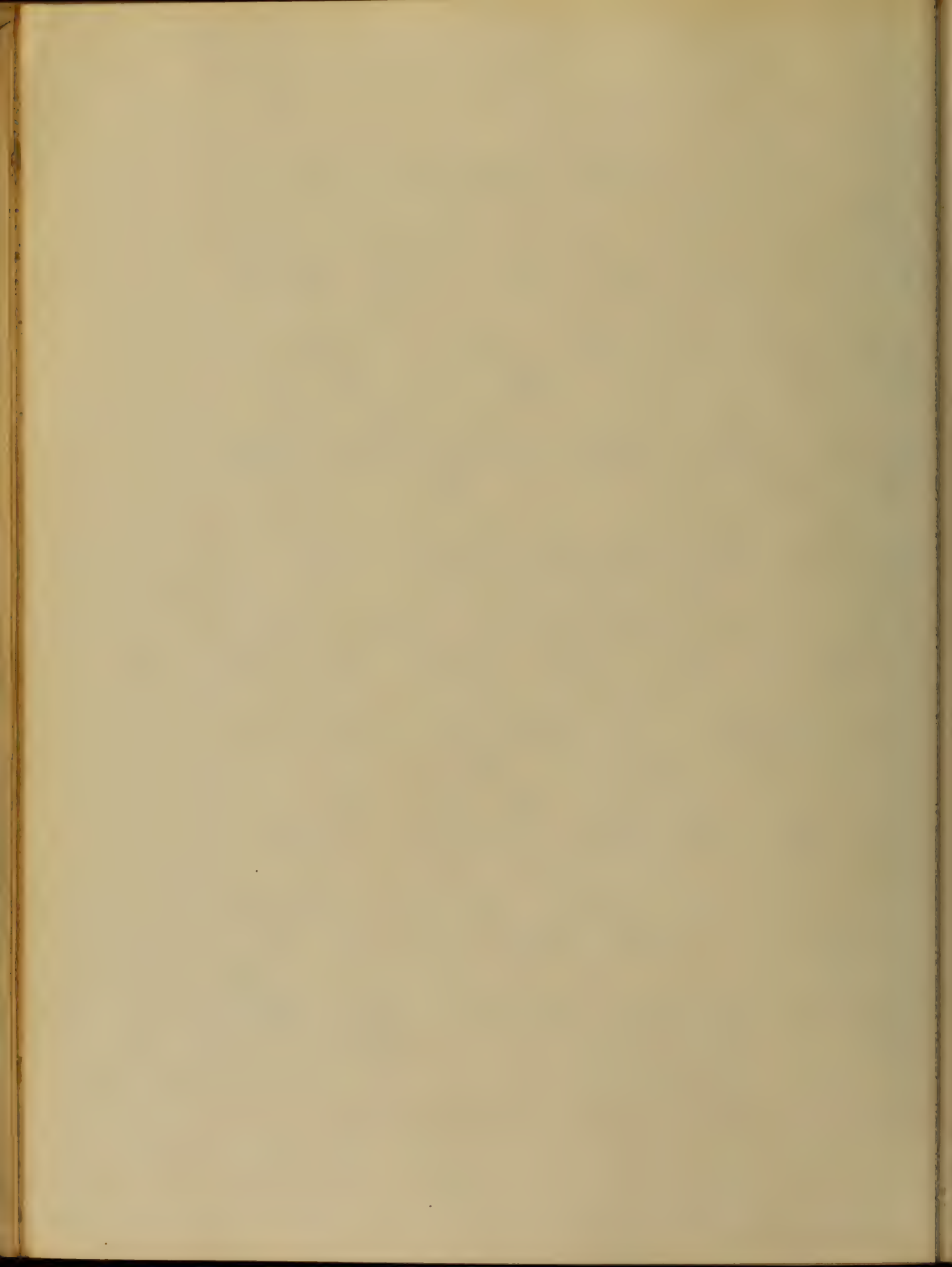
Several remedies have been
proposed for this purpose
- Quinine, Opium, Hot feet,
&c; but all of them



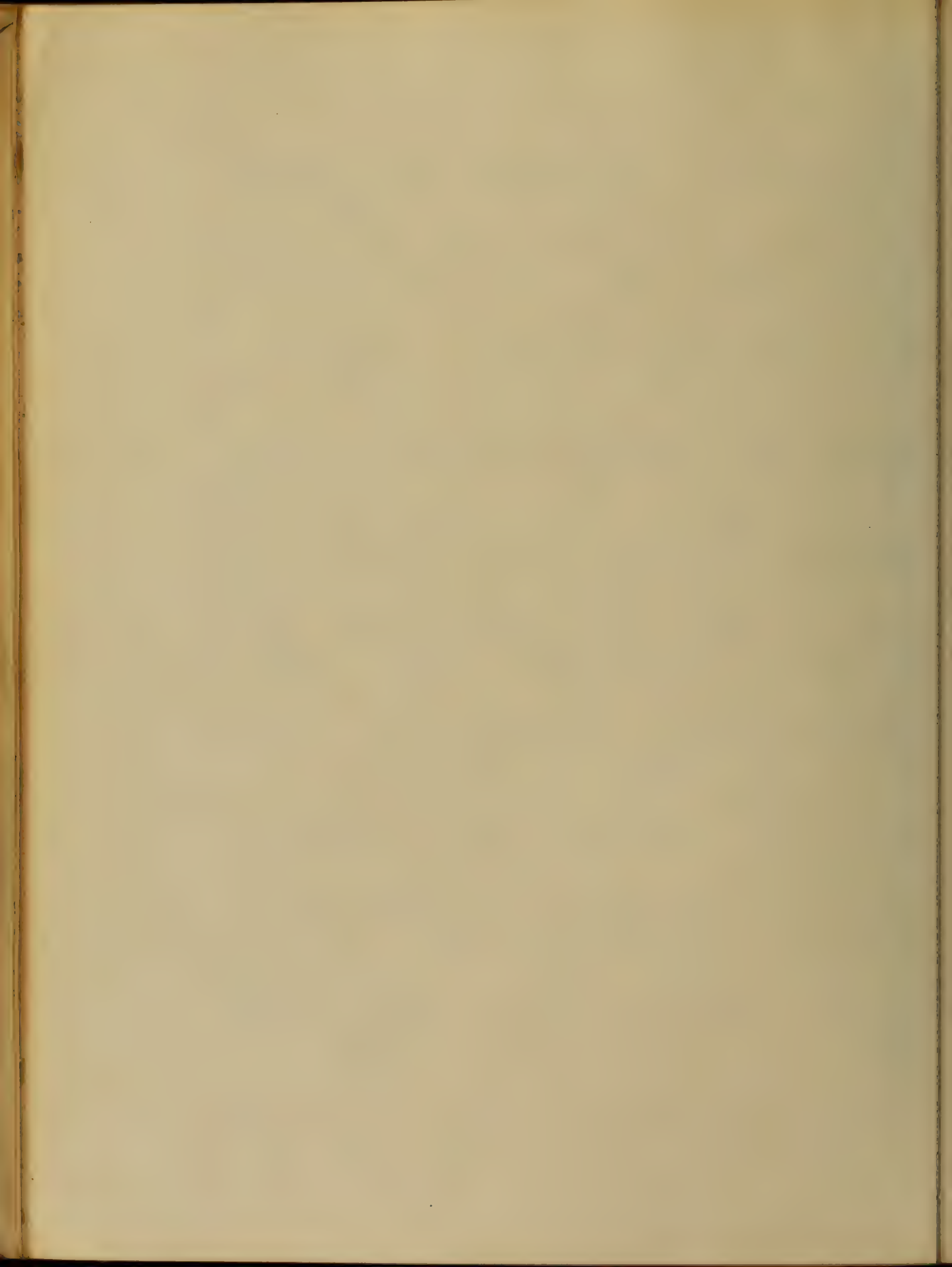
have fallen far short
of their reputed efficacy.
The only correct mode
of treatment is the Ex-
pectant method - that is
watching the disease, Am-
bating the symptoms, and
giving the patient rest
by the use of anodynes.
If the bowels be con-
stipated use a mild
laxative - a teaspoonful
of Castor oil. On the con-
trary if you have per-
sistent diarrhea you may
use opium, with an
astringent - sugar of Lead. Tannin.



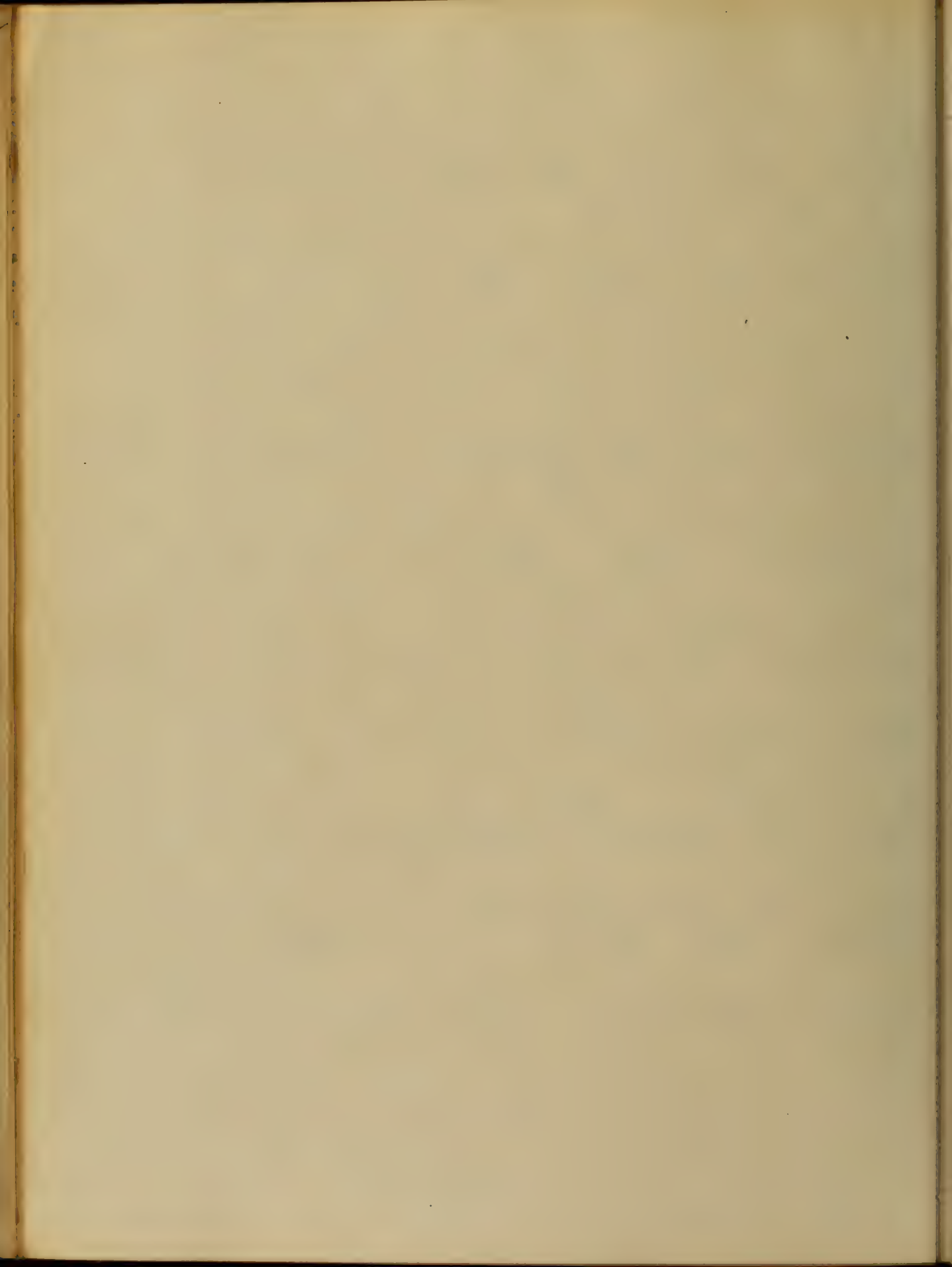
To allay high fever, give
the nitrous powder, oratron
Vivide, or Quinine. Dr. Chess
recommends the use of
Quinine in the highest
terms. For the ulceration of
the bowels, and the intes-
tinal hemorrhages, the
oil of Turpentine is con-
sidered as the best remedy.
It may be given in do-
ses of from five to
twenty drops every two
hours. A red and dry
tongue with diarrhoea, in-
dicate its use. As the
case improves this



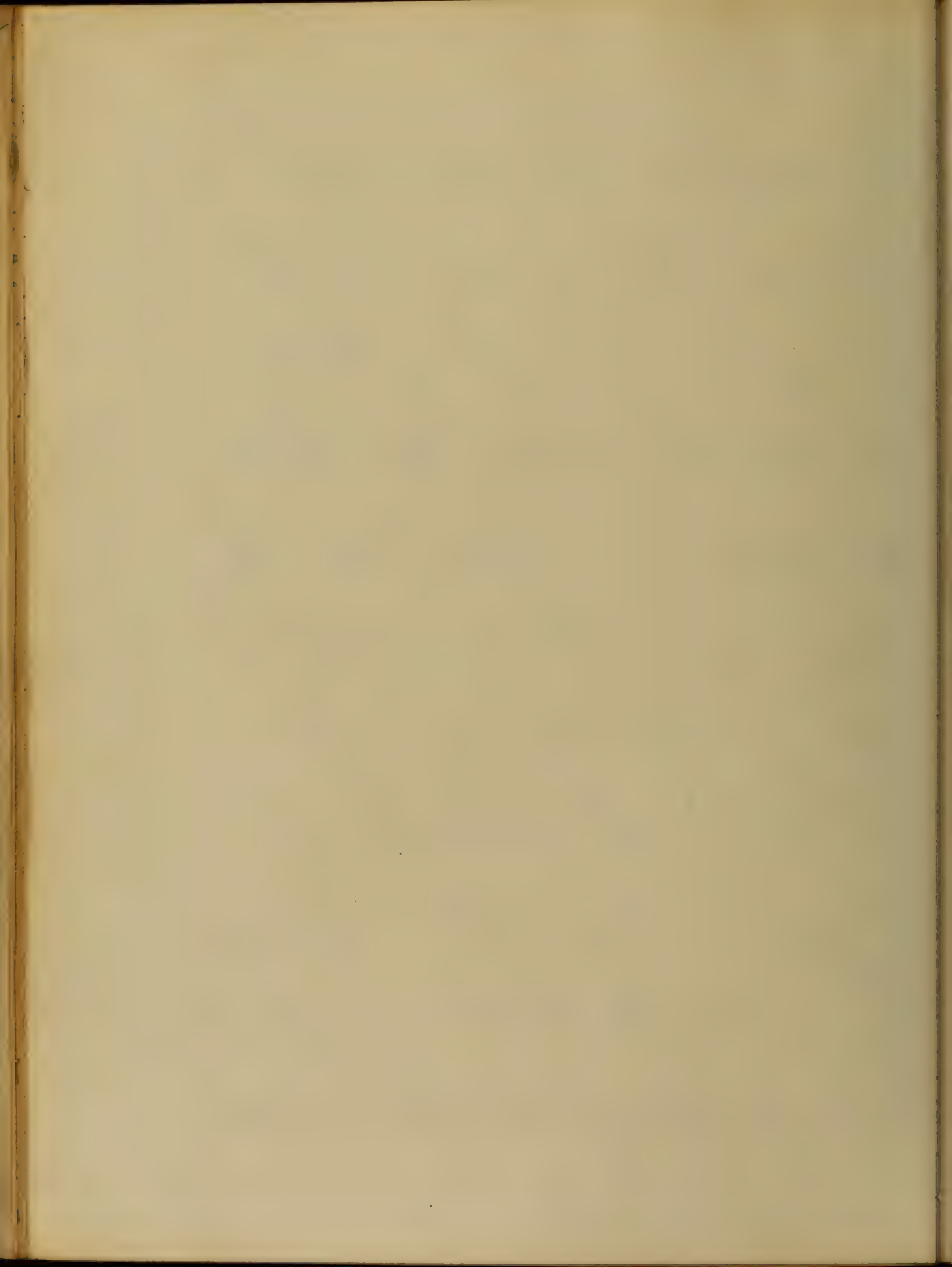
treatment should be gradually suspended. You may use kino or tannic acid for hemorrhage from the bowels. A sudden fall of temperature may lead you to suspect that hemorrhage is about to occur. If the patient become prostrated then the stimulant treatment must be used. The indications for the use of stimulation, are increased frequency of the pulse, with diminished force of the heart action. The



best guide to the force
of the heart is the
resonance of the first
or systolic sound of the
heart. Brandy is the
best stimulant known
and may be admin-
istered in larger quan-
tities in disease than
would be warrantable to
give in other cases. How
from ℥℥ to ℥ij as often
as in your judgment
you may deem advis-
able. The food in these
cases should always be
liquid, and contain as



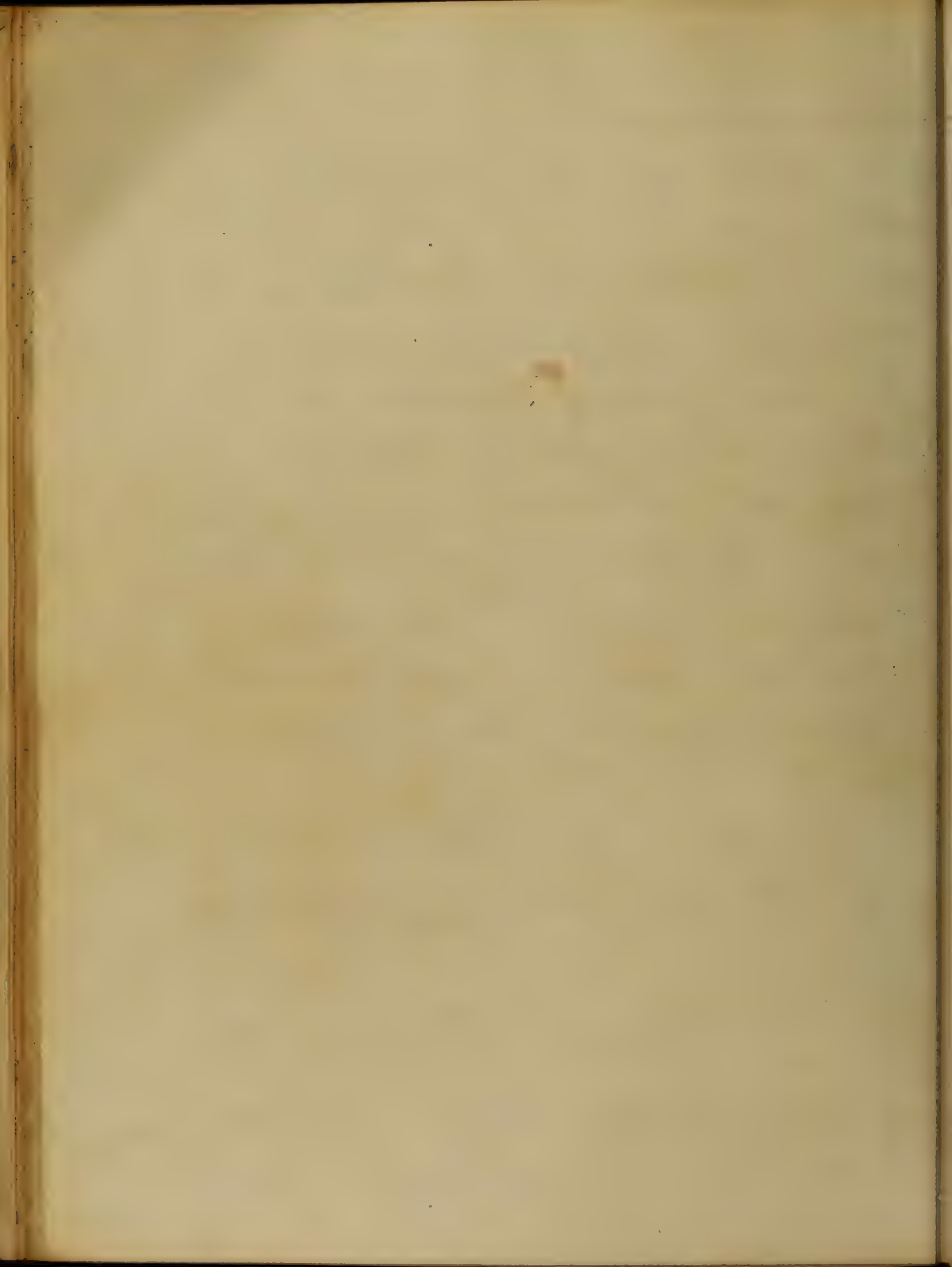
nutrition as possible.
Beef tea is an excellent
diet, so is milk. The pa-
tient's head should be shaved
as soon as the diagnosis
is clearly made. The hygie-
nic measures should be as
favorable as possible - the
carpets should be removed
and all woolen goods that
can be dispensed with.
Plenty of fresh air is
a thing indispensable
and should not be
neglected by any means.
The acid treatment is much
extolled by some writers
and is based on the paper

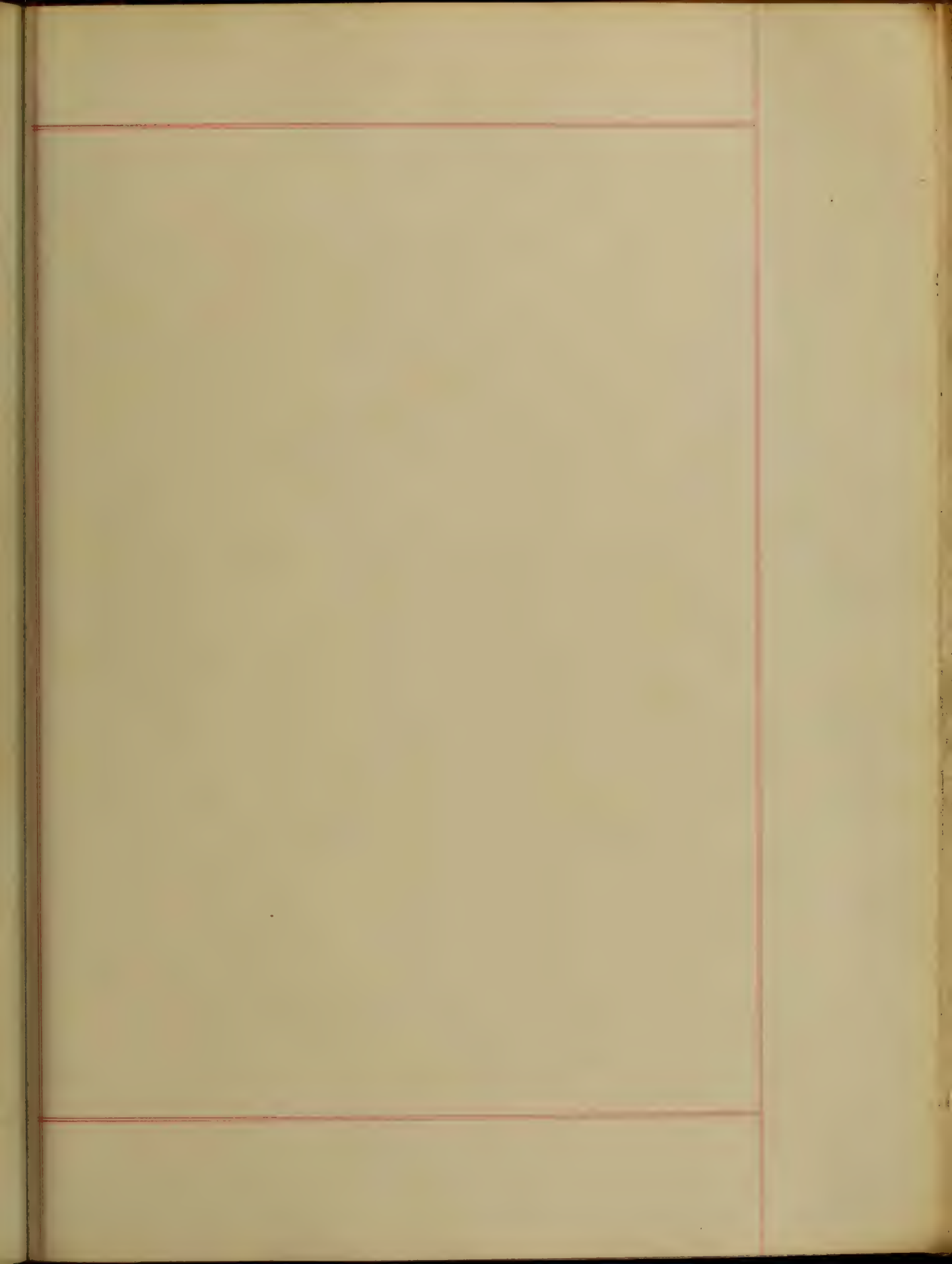


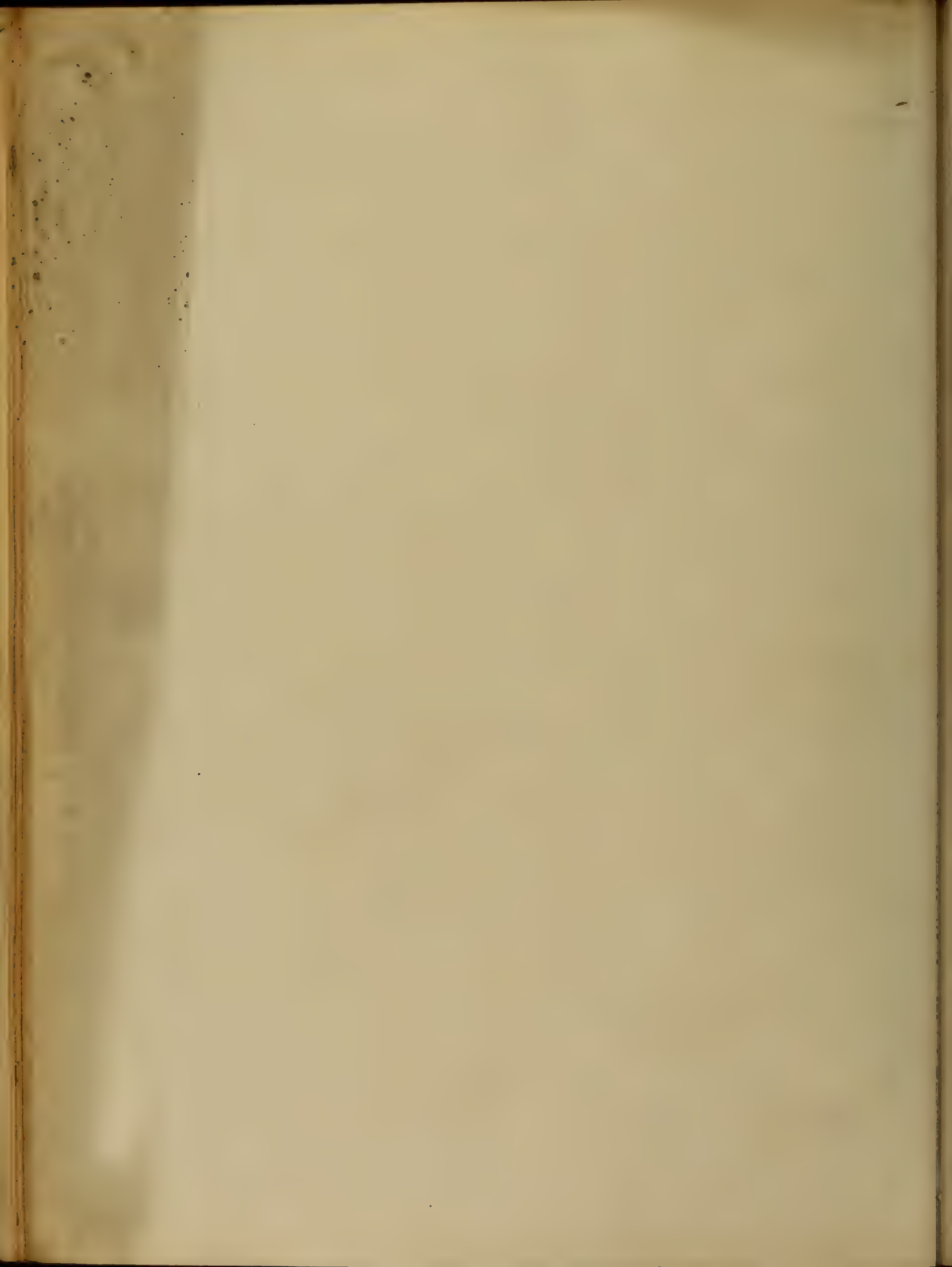
the theory of the superabun-
dancy of the blood. The Sul-
phurous is most highly
recommended, or better still
the sulphite of soda. To
sum the whole thing
into a short sentence —
Vary your remedies ac-
cording to the special
indications, and do not
follow a routine prac-
tice.

Very Respc^l

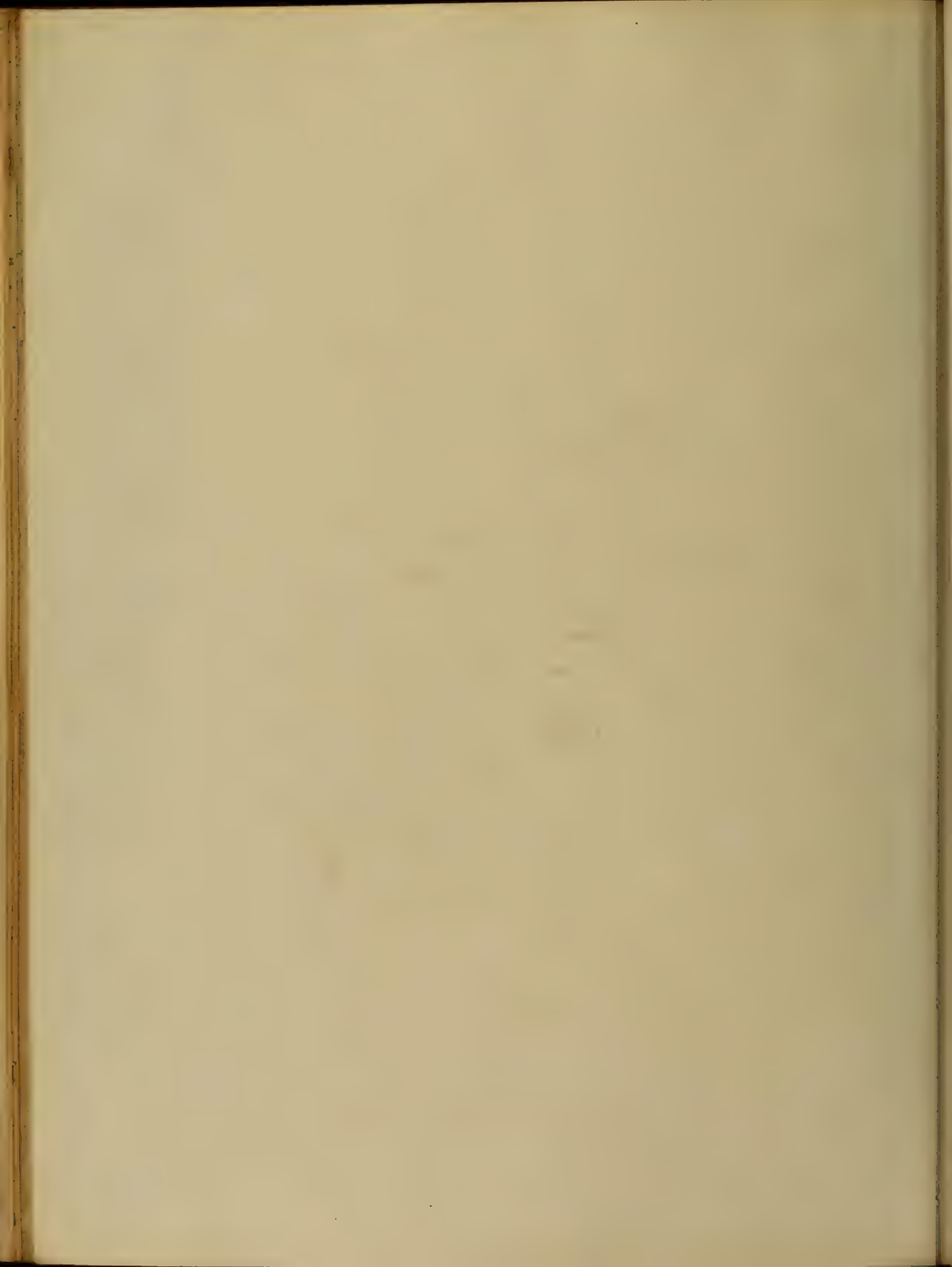
J. B. Harvey
"



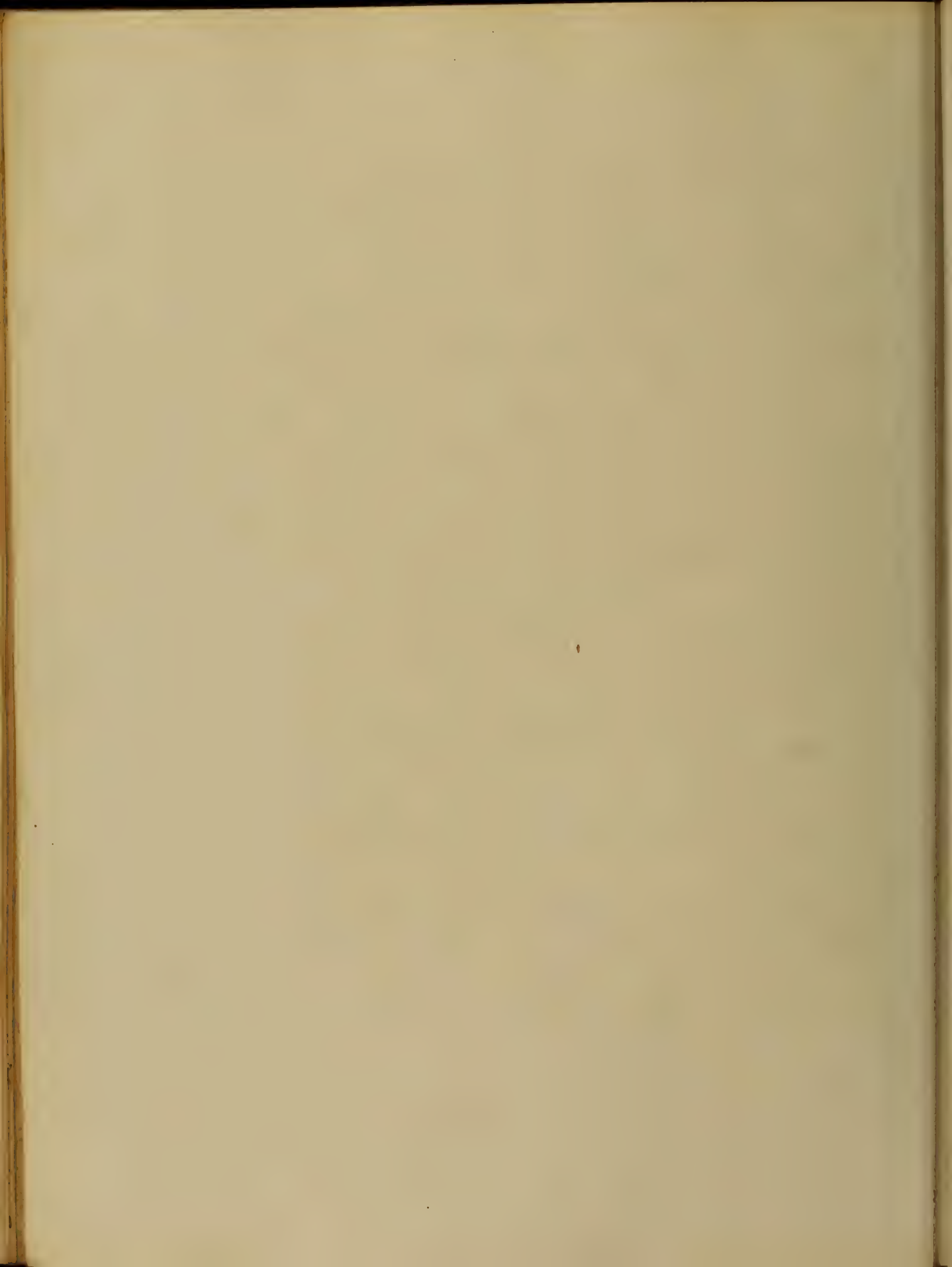




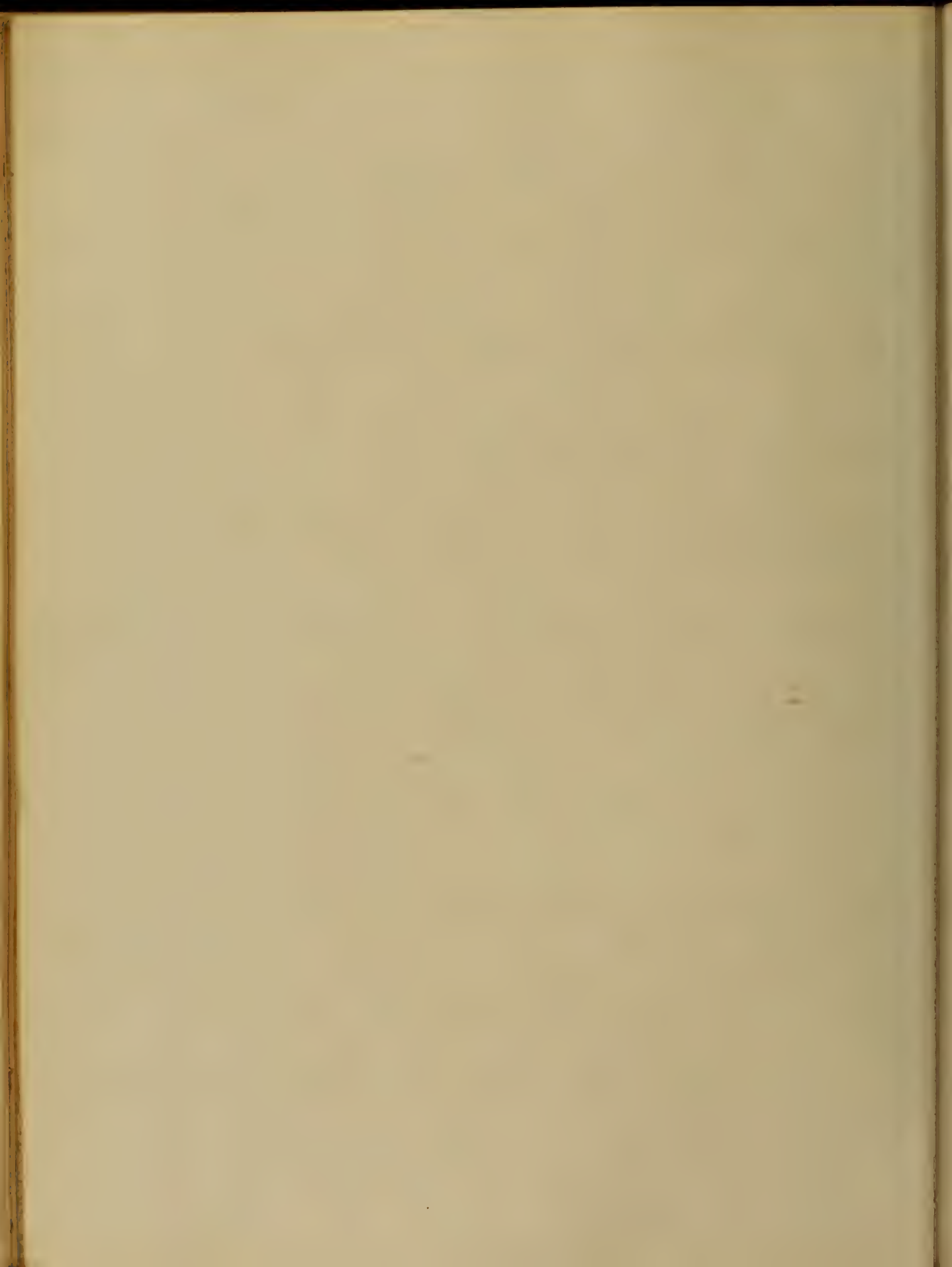
Thesis
on
Ovaridomy
by
A. Temple - Shebick
of
North - Carolina
Class of 1876 + 7



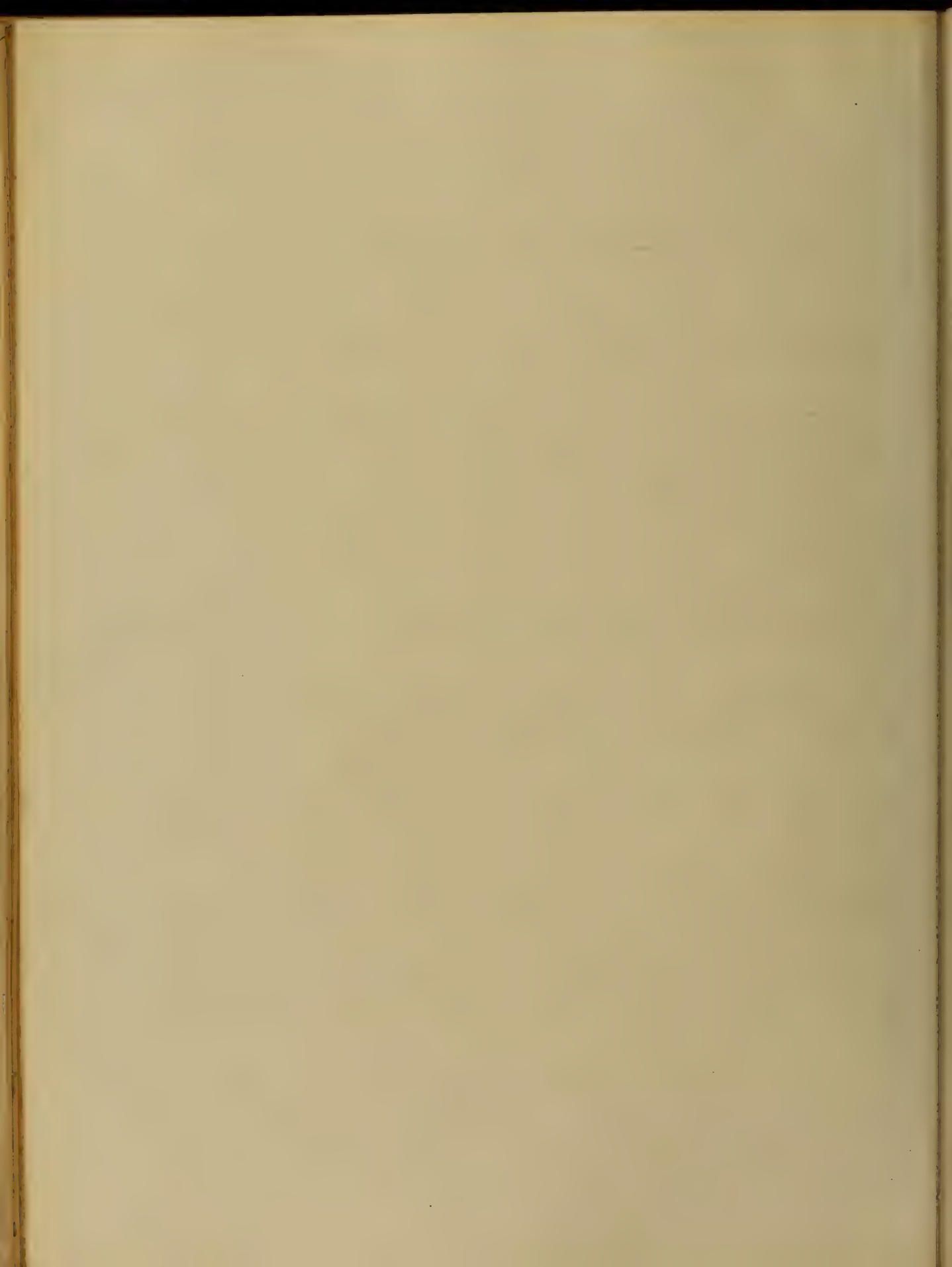
Ovariotomy is the operation
for the extirpation of the ovaries,
including the crania. This operation,
which was at one time looked on
as a death-sentence by the public
opinion, and even condemned by
many prominent gentlemen of
the medical profession, is now
numbered among the most bril-
liant triumphs of modern sur-
gery, it was first performed by
Dr. John Hunter in 1789,
although several attempts have
been made by European writers
to attribute that honor to British
Surgeons. Dr. Hunter's operations were
very successful, and he was the first



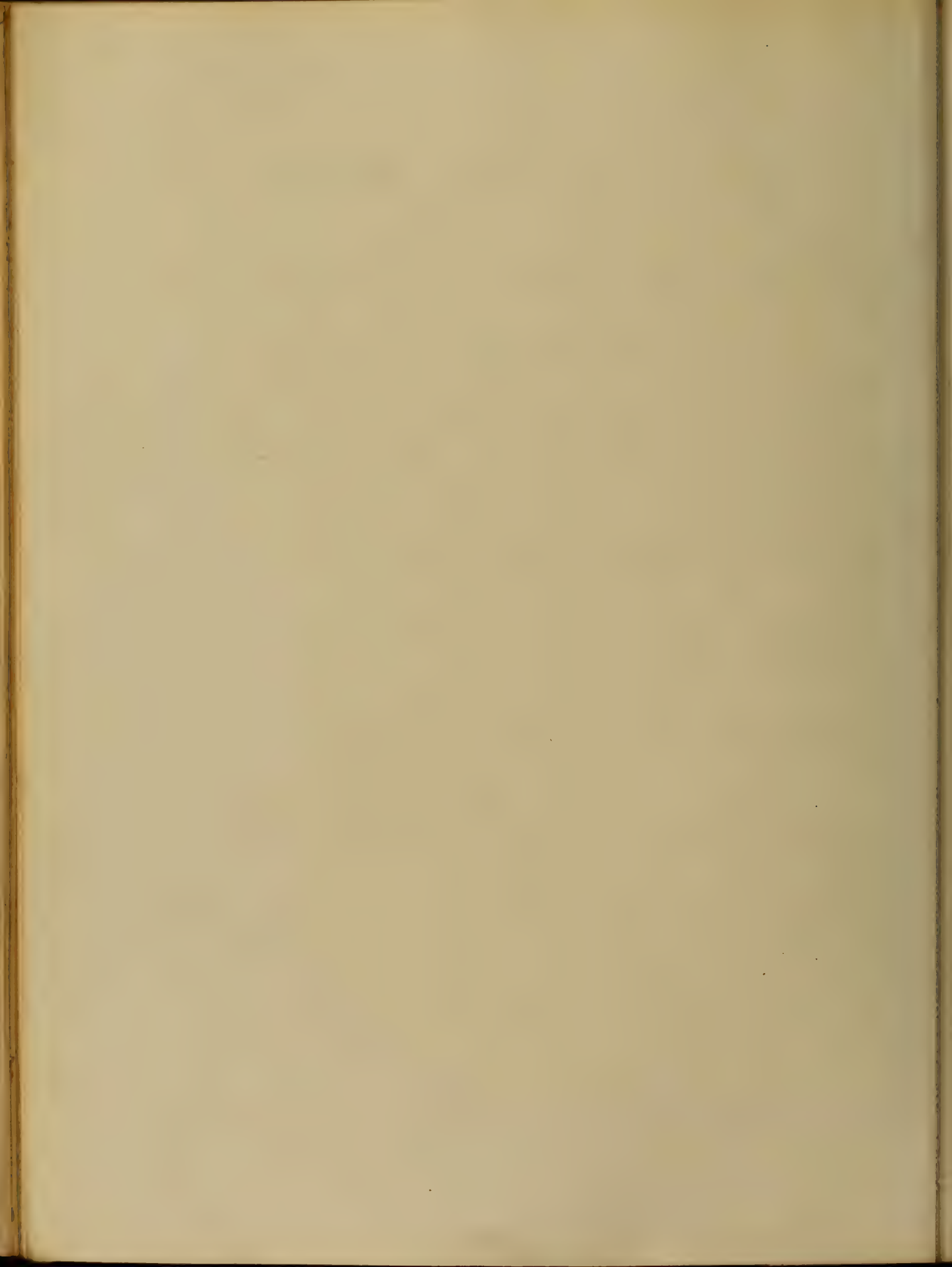
example was followed by many
 American surgeons, with varied
 success, and still less favorable re-
 sults were obtained in Europe, so
 that the operation was again un-
 der bad repute, and it was not
 until within the past twenty
 years that the benefits to be de-
 rived from the operation were
 fully realized or appreciated by
 the profession as a body, up to
 that time some sort of opinion
 that the tumors might be cured
 by medicine, and after a trial of
 almost all known drugs this
 plan was abandoned, then it was
 that tapping was introduced



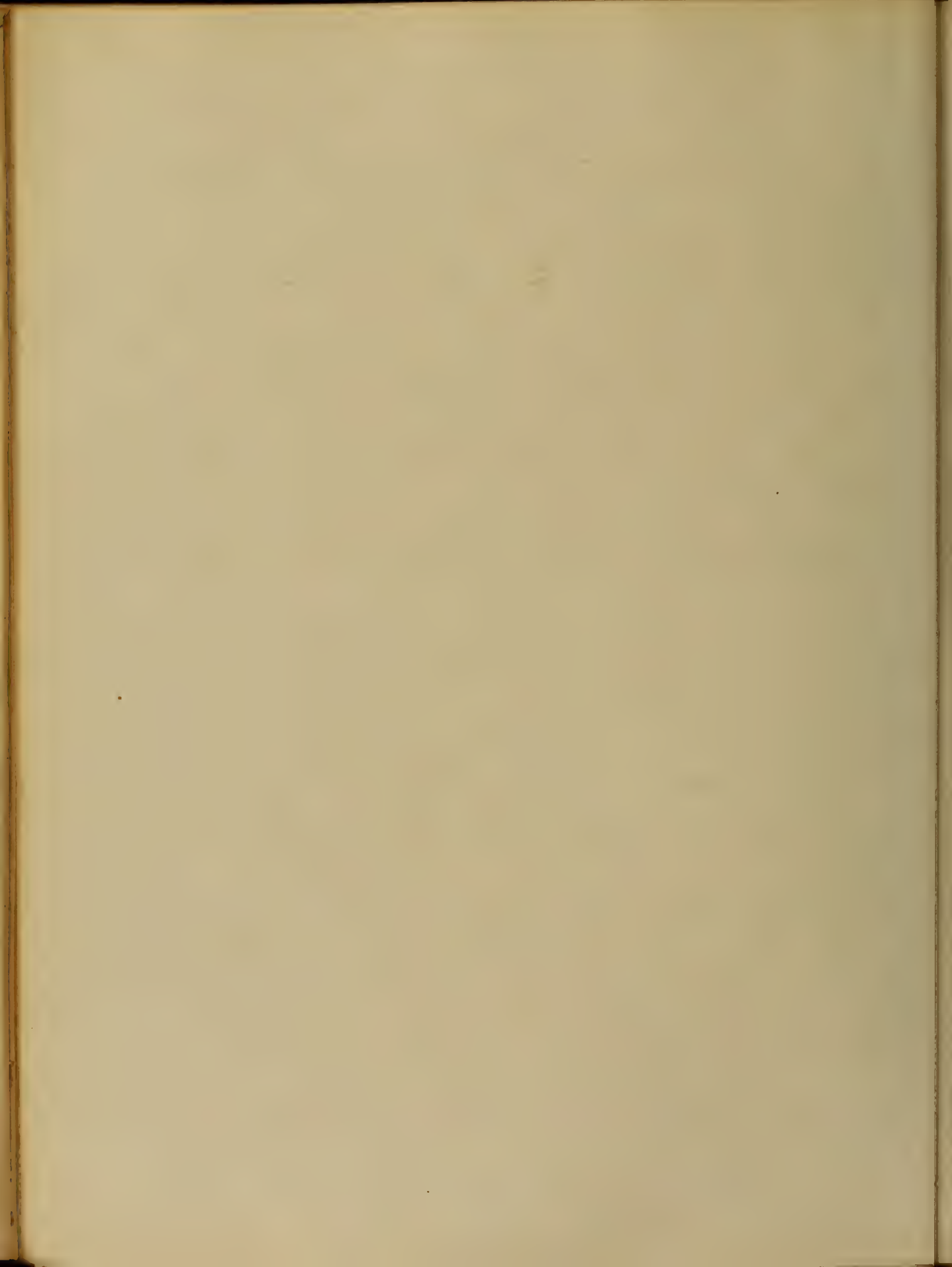
into practice, and although not
 as beneficial as was expected, it
 proved to possess some merit. Dr.
 F. W. Simpson reports that, and
 Dr. J. H. Reynolds, etc., cases cited
 in this way, however, there seems
 still to be great diversity of
 opinions in regard to this mat-
 ter, some advocating and others
 opposing the operation, the lat-
 ter class holding that tapping at best
 is only palliative, and that it is
 followed by adhesions or other con-
 ditions which add greatly to the
 danger of subsequent hemorrhage.
 On the other hand, it is ac-
 cepted by many that it



writers, for instance Drs Barnes
 and Spencer Wells, both reliable
 authorities upon this subject,
 state that although tapping is
 only palliative it does prolong
 life and allows the surgeon time
 to get his patient's system in a
 condition to bear the severe
 operation of extirpation, and
 that it is a mistaken idea to
 suppose that it causes fatal re-
 sults in ovariotomy, Tapping
 may be performed either through
 the abdominal cavity or the
 anterior abdominal wall, and
 the former is considered
 at the best of times, the tapping
 the safer way, the latter is

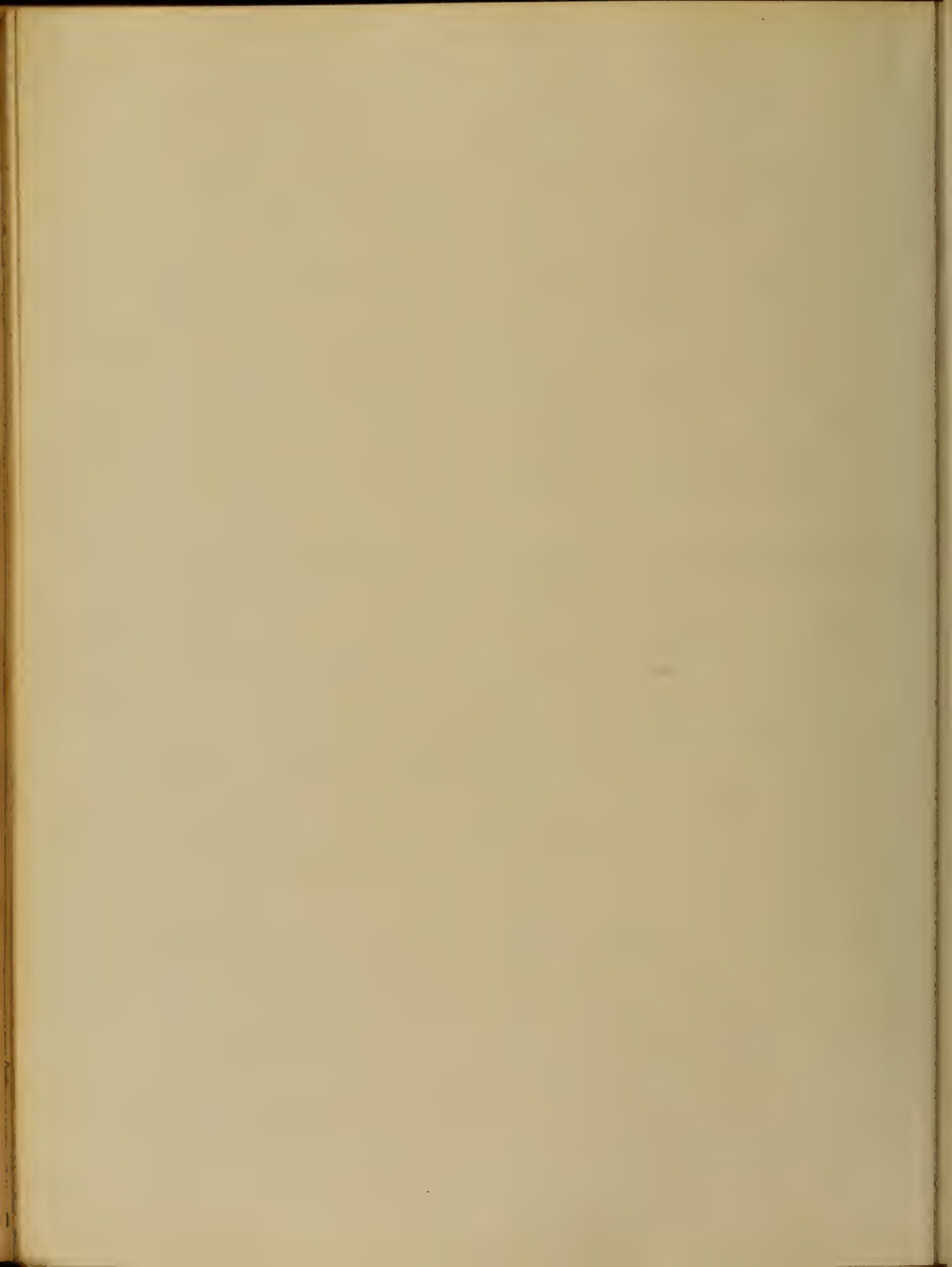


Disease, with the view of its
 organizing its tissues and pro-
 moting absorption, this plan, as
 before stated is only pai-
 liative, and sooner or later mani-
 festing in some of the following.
 These tumors are divided into
 two great classes, the solid and
 cystic, the first consists of the
 fibrous tissue, but in the
 latter attain a size sufficient to
 demand extirpation, and are
 therefore foreign to my subject,
 I will pass them over, the se-
 cond class have been arranged
 under three heads, 1st Monocysts.
 2nd Polycysts, and 3rd Dermoid

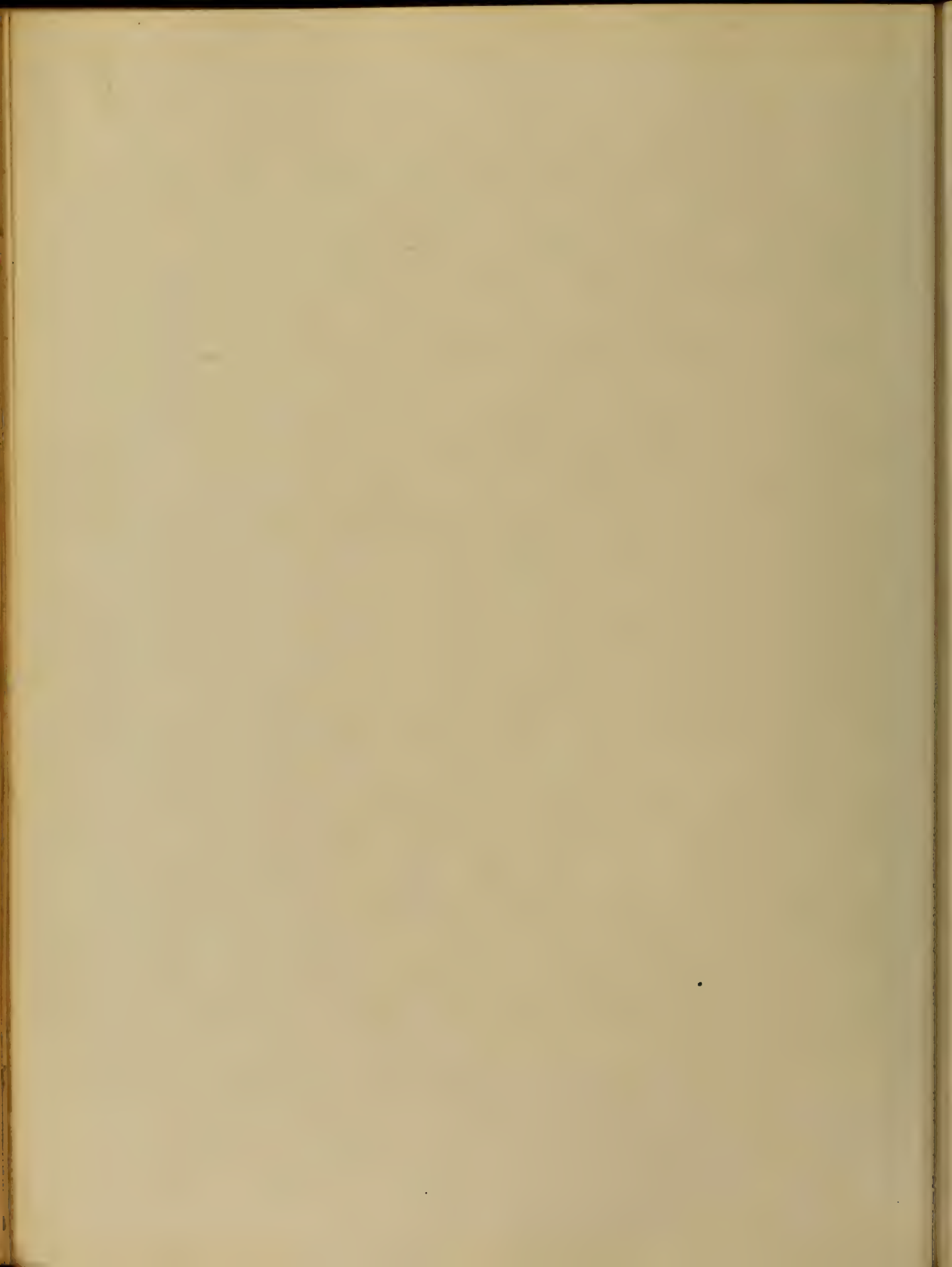


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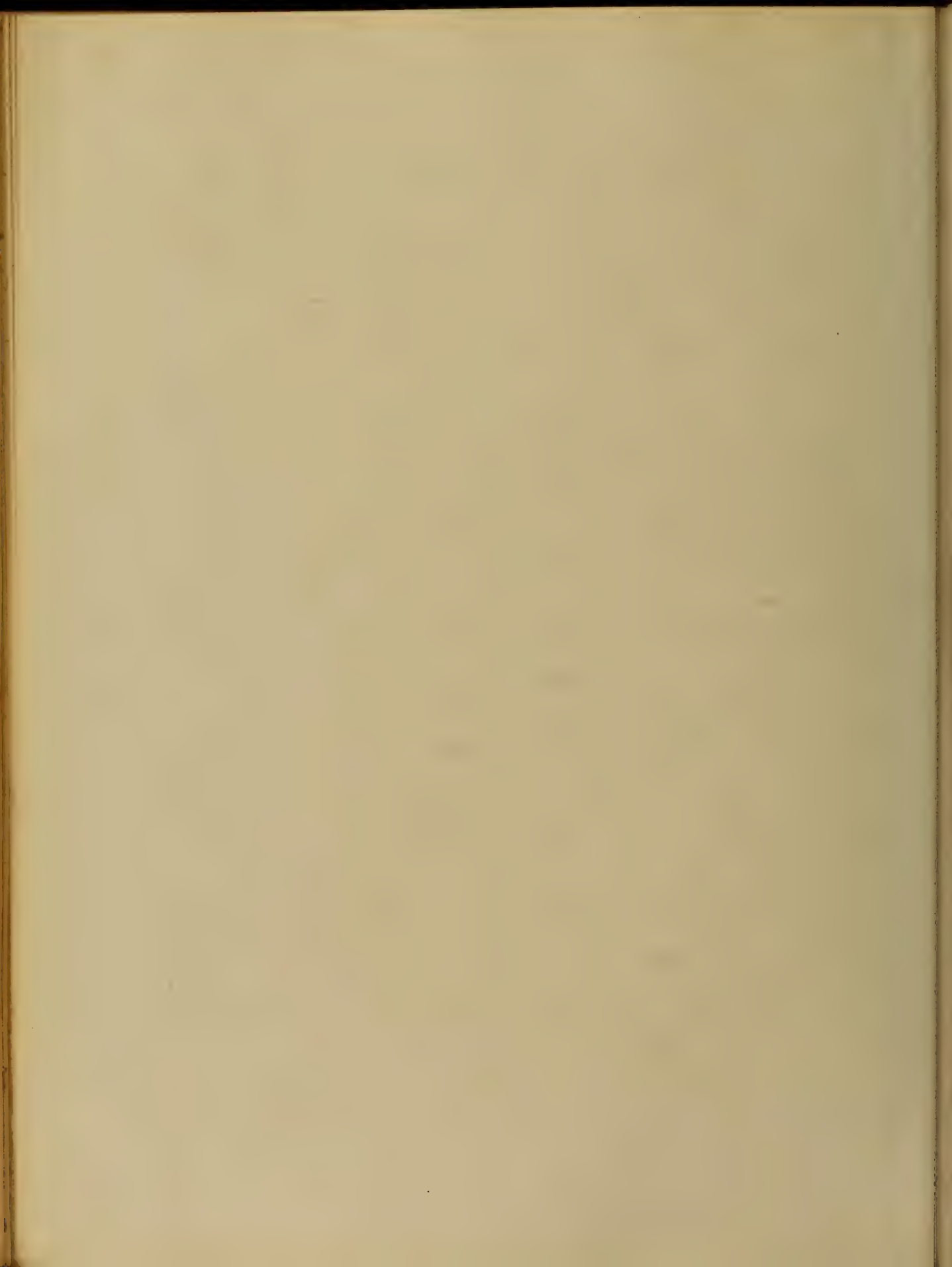
cysts, the first often attain im-
mense size, and as a rule their
growth is much more rapid
than the other kinds, these are
supposed to originate from an
altered and enlarged Graafian
vesicle, the third are rather
rare and never grow to any size,
they present irregular surface
with thick walls, and contain
a thick lard or butter like sub-
stance of a yellowish color, also
hairs, teeth, and bones, nothing
definite is known as to the cause
of this strange phenomenon, path-
ologists at one time held that
they were the remains of an ex-



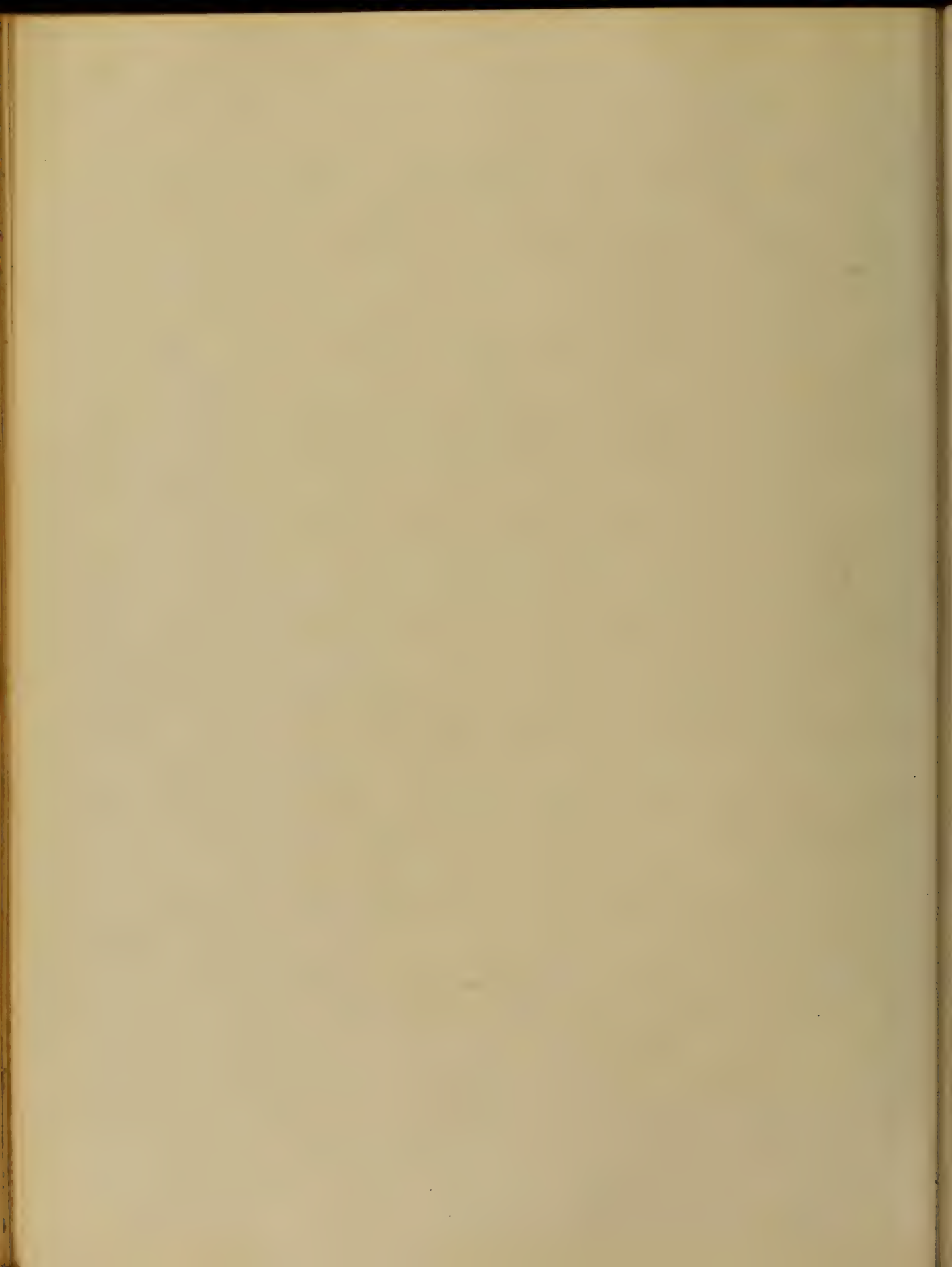
An uterine impregnation, but
 this theory is negated by the
 fact that these tumors have been
 found in children, and even
 in the scrotum of the male,
 they also seldom demand our at-
 tention in this connection, the se-
 cond class, the *Polypoid* are the
 ones that are of most interest;
 they are caused by the morbid
 development of several Glandular
 vesicles, and consists of a large
 one each increasing other cysts
 of all dimensions, these in their
 turn increasing other smaller
 ones, the fluid contained in
 them is generally thin and



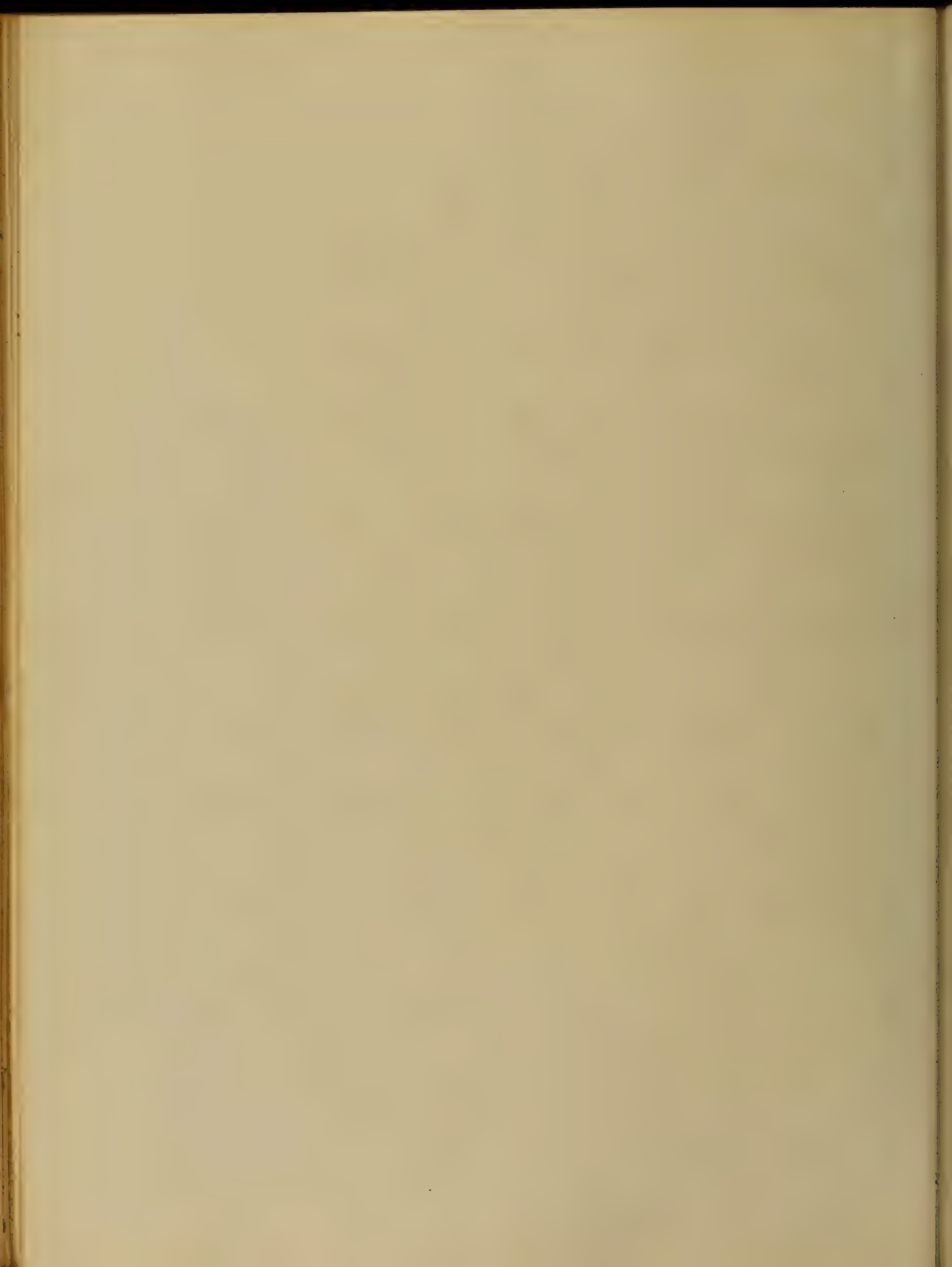
watery, but not exclusively so,
 for at times it is found to be of
 the consistency of thin jelly, mixed
 with blood and pus. Ovarian
 tumors are diagnosed from other
 enlargements of the abdomen by
 the history of the case, by inspec-
 tion and measurement, by pal-
 pation, and by auscultation
 and percussion, the two con-
 ditions most nearly resembling
 ovarian tumors are ascites and
 pregnancy, in ascites the ab-
 domen is symmetrically enlarged,
 and after change of position
 the fluid gravitates to the in-
 ferior part, and the greatest



circumference is found to be at
 the umbilicus, while in ascites
 usually the abdomen is more en-
 larged on one side than the
 other, and the arrangement does
 not vary with change of position,
 and the greatest circumference
 is found to be some distance
 below the umbilicus, percussion
 in ascites gives a clear sound over
 the middle of the abdomen, while
 around the edges the sound is dull,
 the former gives a dull sound in
 every part, the diagnosis between
 them and pyelitis is also made
 by the history of the case, by aus-
 cultation, and by vaginal exami-

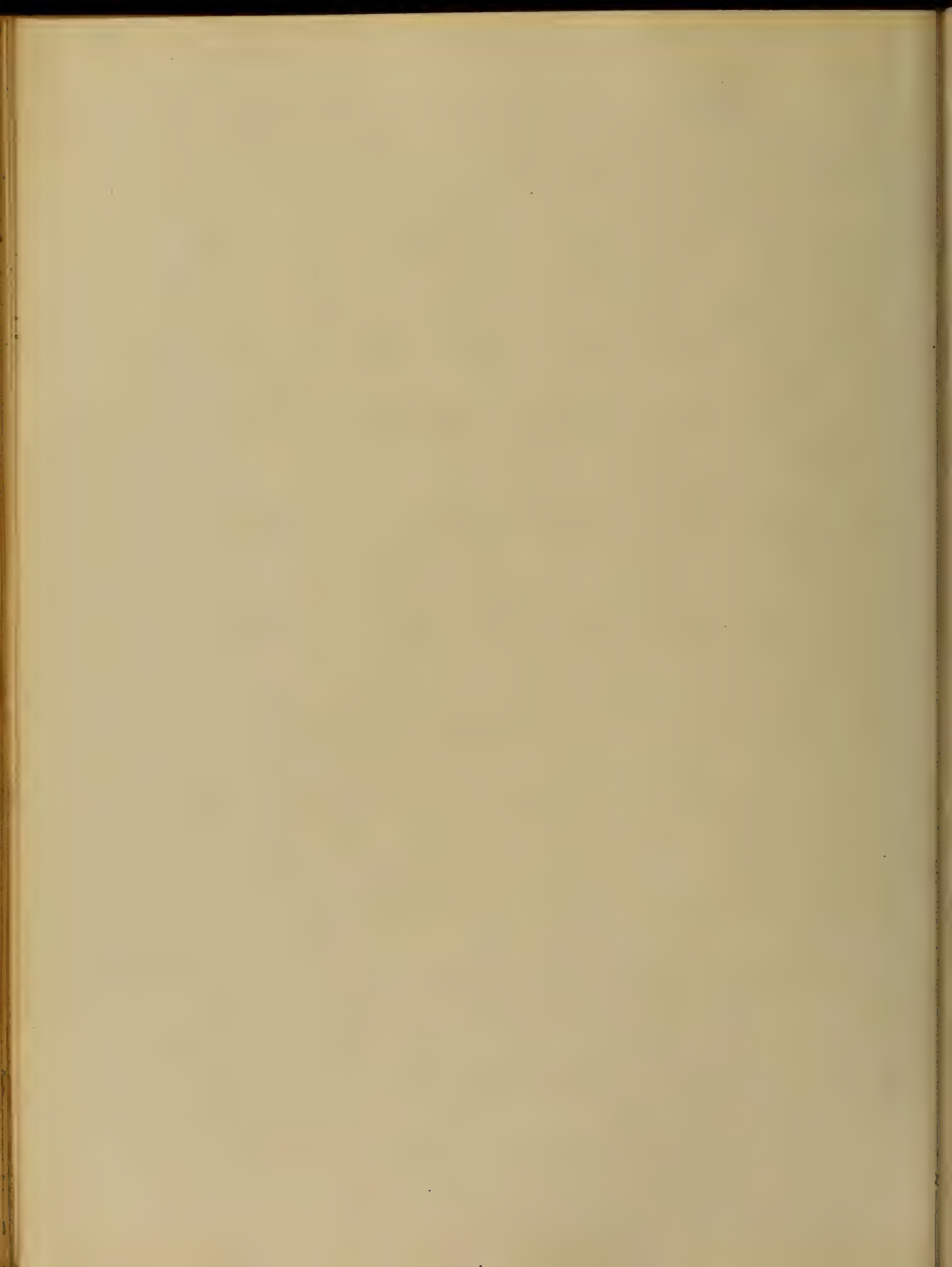


nation, if the history gives rise
 to suspicions of pregnancy, the
 stethoscope will reveal the beating
 of the foetal heart, and if the
 uterus is enlarged, and the ex-
 amination can be obtained, it will
 settle the matter beyond a doubt.
 After the surgeon is satisfied that
 he has no deal with an ovarian
 cyst, he should try to get his
 patient's system in as good con-
 dition as possible, for this pur-
 pose Dr Simpson recommends
 a course of the best kind of
 iron, and Dr Wells a combina-
 tion of iron and the carbonate of
 lithia, with the bicarbonates of

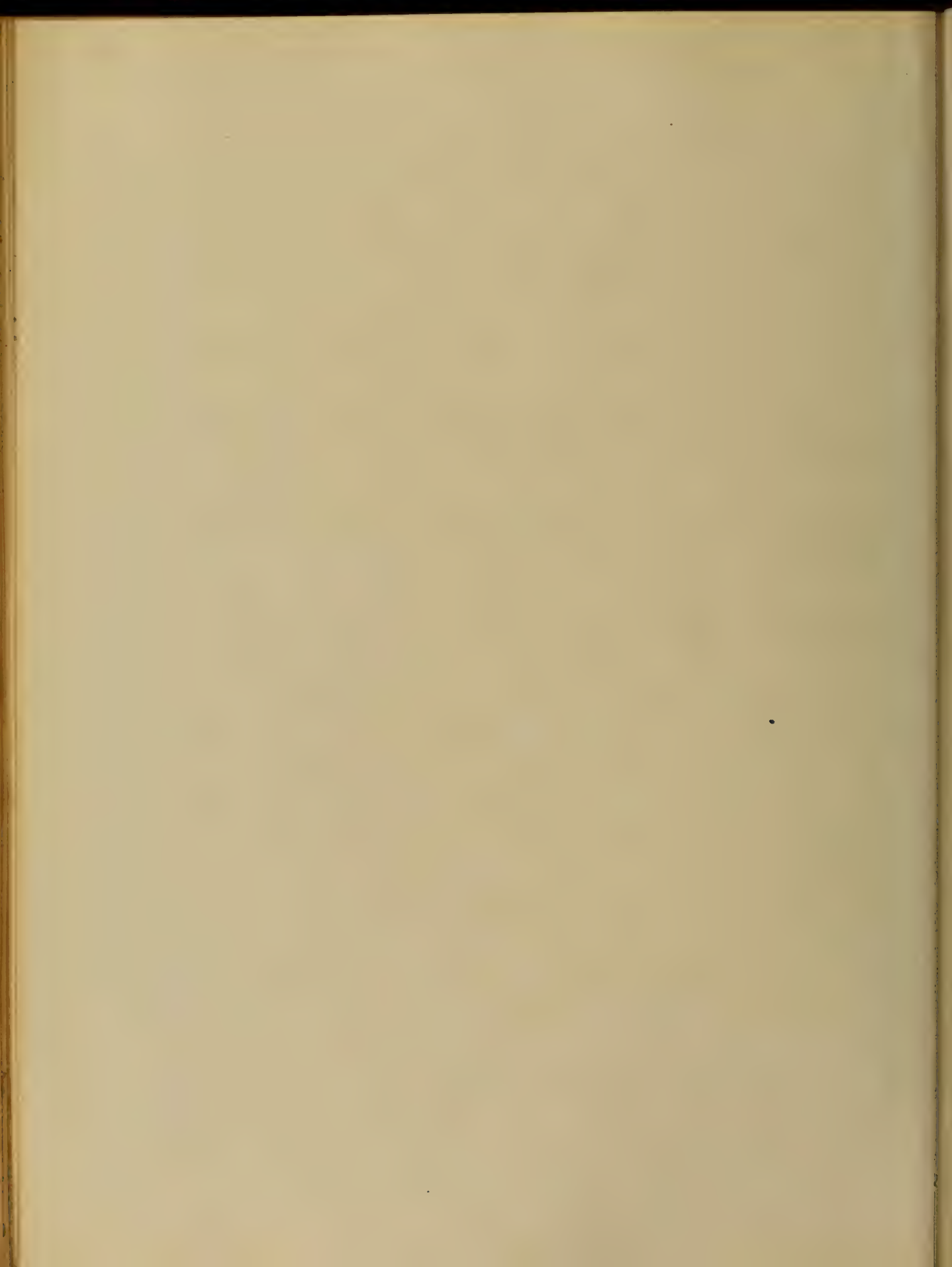


spoke and so on, with the
 double view of regulating the
 action of the kidneys, and re-
 storing the blood to as healthy a
 condition as possible before oper-
 ating.

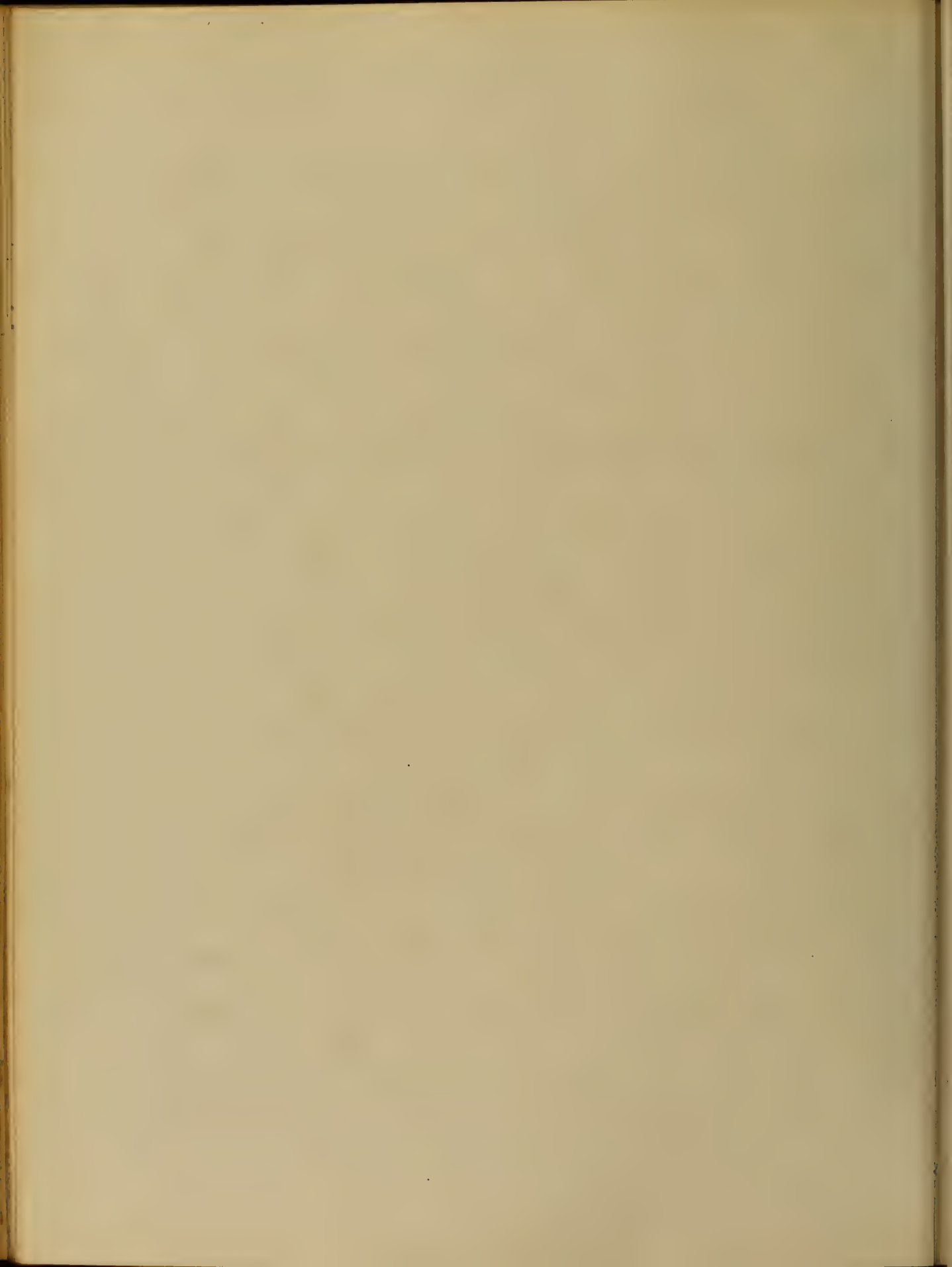
The instruments necessary for
 this operation are few in number
 1st a scalpel, a dissector, a pair,
 a clamp, needles and silk, for-
 ceps and ligatures, - all things
 being in readiness the surgeon
 commences his incision one inch
 below the umbilicus and carries
 it along the median line to
 in two inches of the symphysis
 pubis, cutting down to the linea



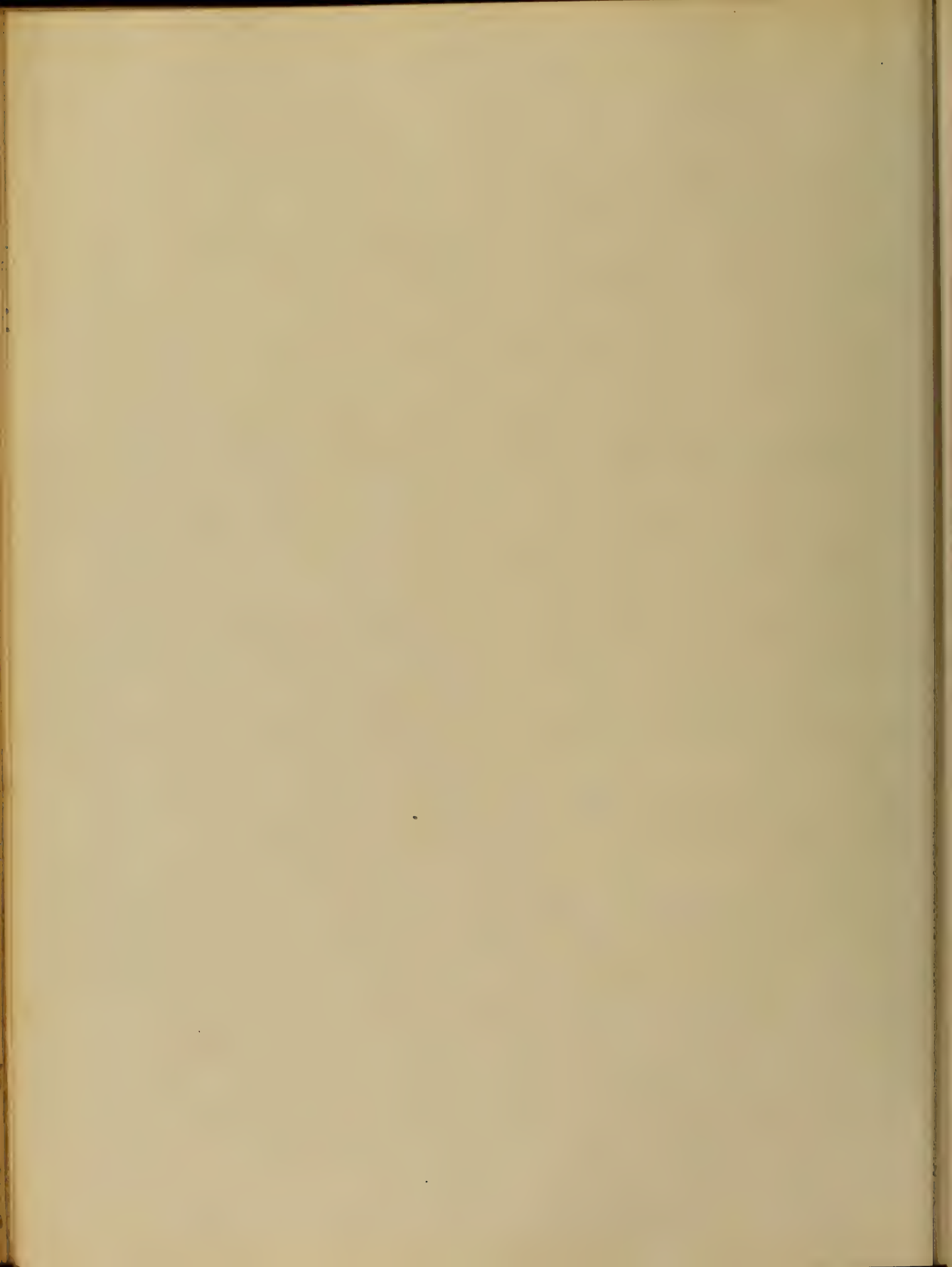
alba at the first stroke, then it
 and the fat beneath is carefully
 divided until the peritoneum
 is brought into view, when if there
 is any fluid there it is wiped off,
 it will bulge through the open-
 ing, this must be expected, and
 the edges of the wound are carefully
 sponged off, and one hand is
 raised slightly and the patient
 as to prevent any bleeding into
 the cavity, when the peritoneum
 is opened, this is done by catching
 it up with a hook and dividing
 it in a direction at the full ex-
 tent of the outer opening, it
 brings into view the glistening sur-



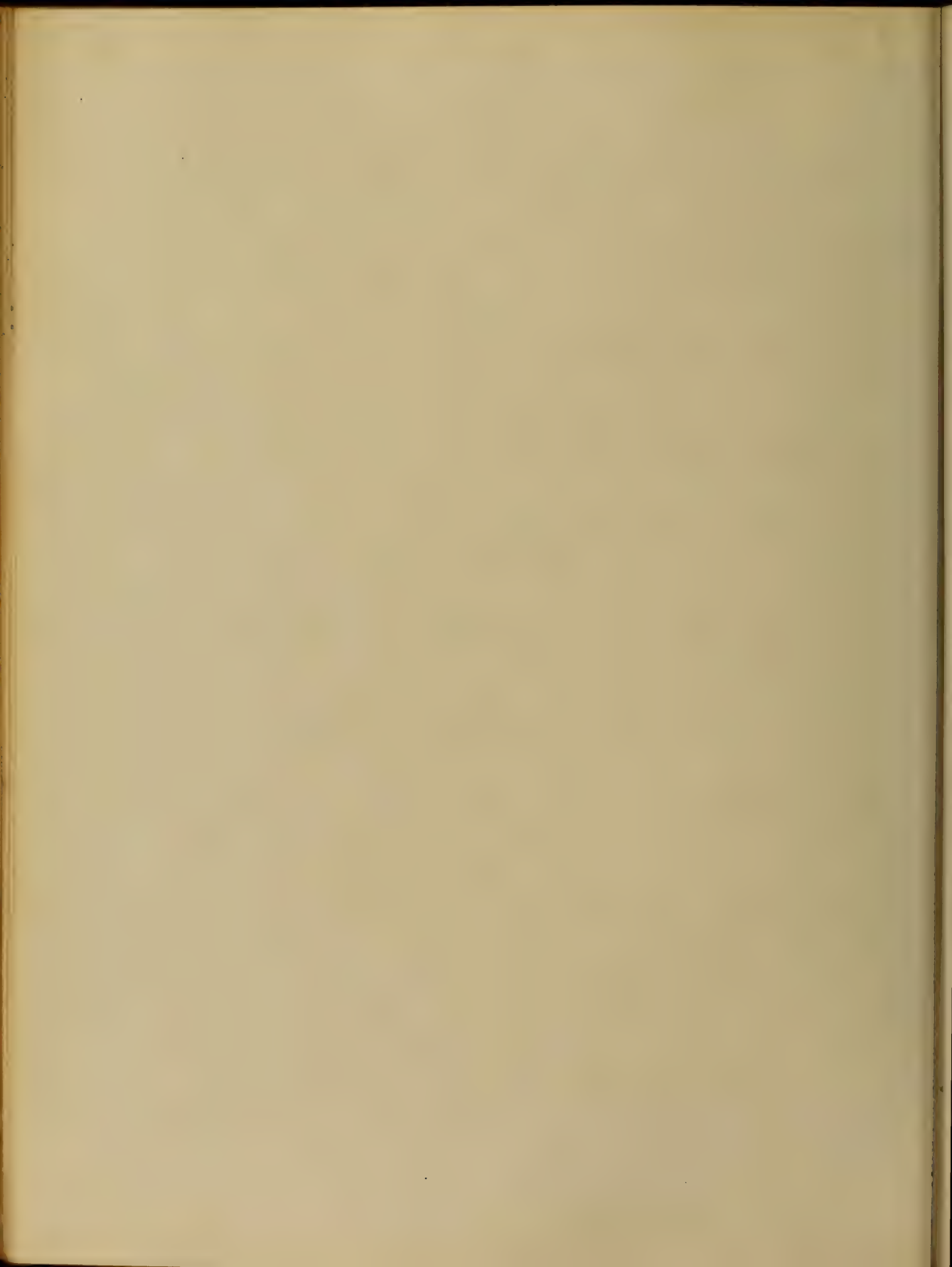
face of the tumor, which must
 now be emptied as near as pos-
 sible by the trocar, when the na-
 ture and extent of the adhesions
 can be seen, these in most in-
 stances can be broken down by
 the hand being passed between
 the tumor and the peritoneum,
 after a minute scan the in-
 divided tumor is gently drawn
 through the opening, and all other
 adhesions stripped off as it comes
 out, it must now be supported
 by an assistant while the surgeon
 proceeds to adjust a clamp upon
 the pedicle, which is composed of
 the broad ligament and fallopian



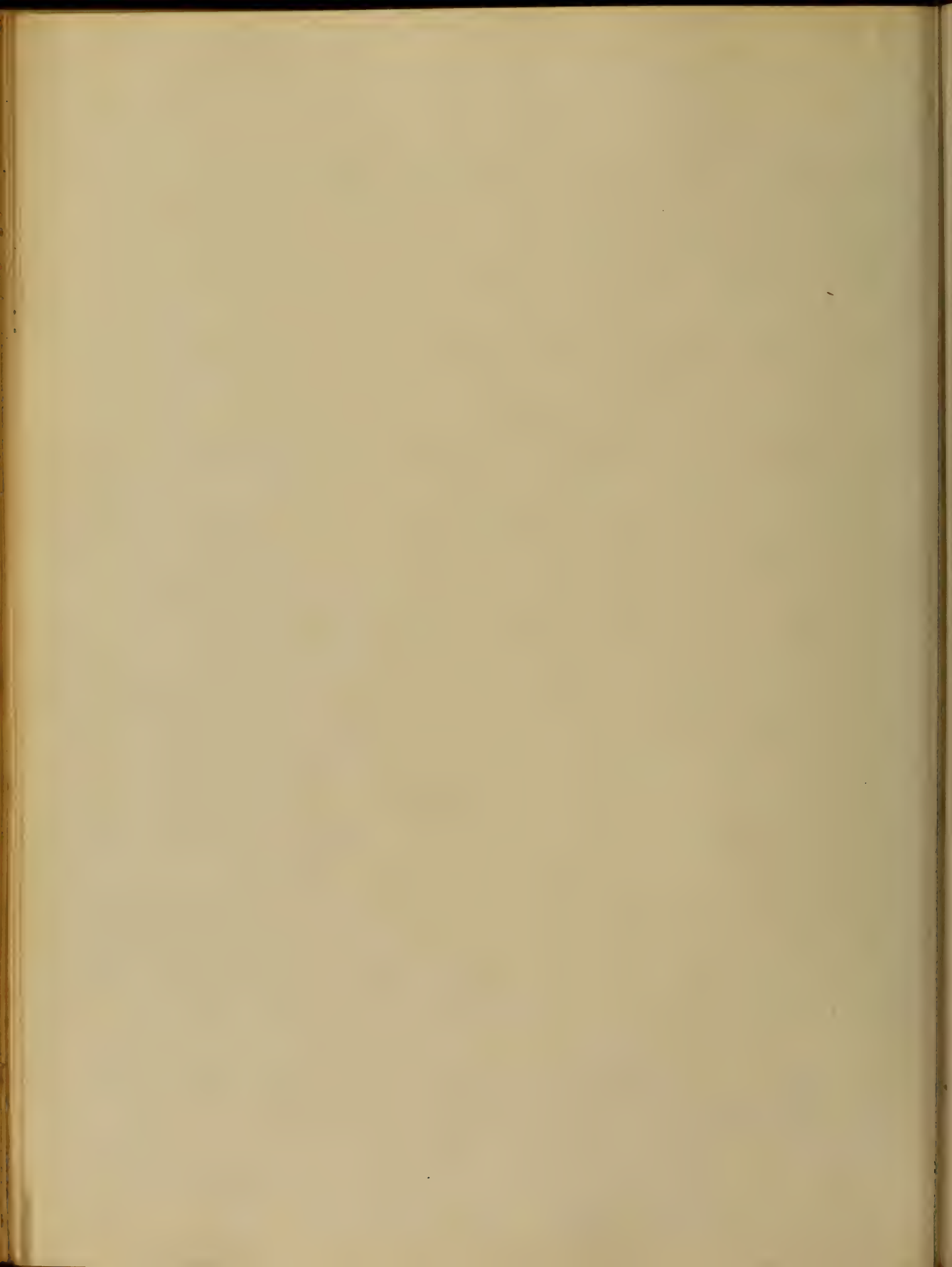
tubes with large arteries and
 veins, after it is secured it is cut
 off about an inch from the clamp
 and the stump is treated with the
 perchloride of iron to prevent
 suppuration, the peritoneal cavity
 is now sponged out clearly and
 the wound closed by interrupted
 sutures which are passed
 through the whole thickness of the
 walls so as to catch the peritoneum
 if necessary superficial sutures
 may be placed between these, the
 surface of the abdomen is now
 covered with a wet dressing
 and the patient is supported with
 emollient fomentations perineum



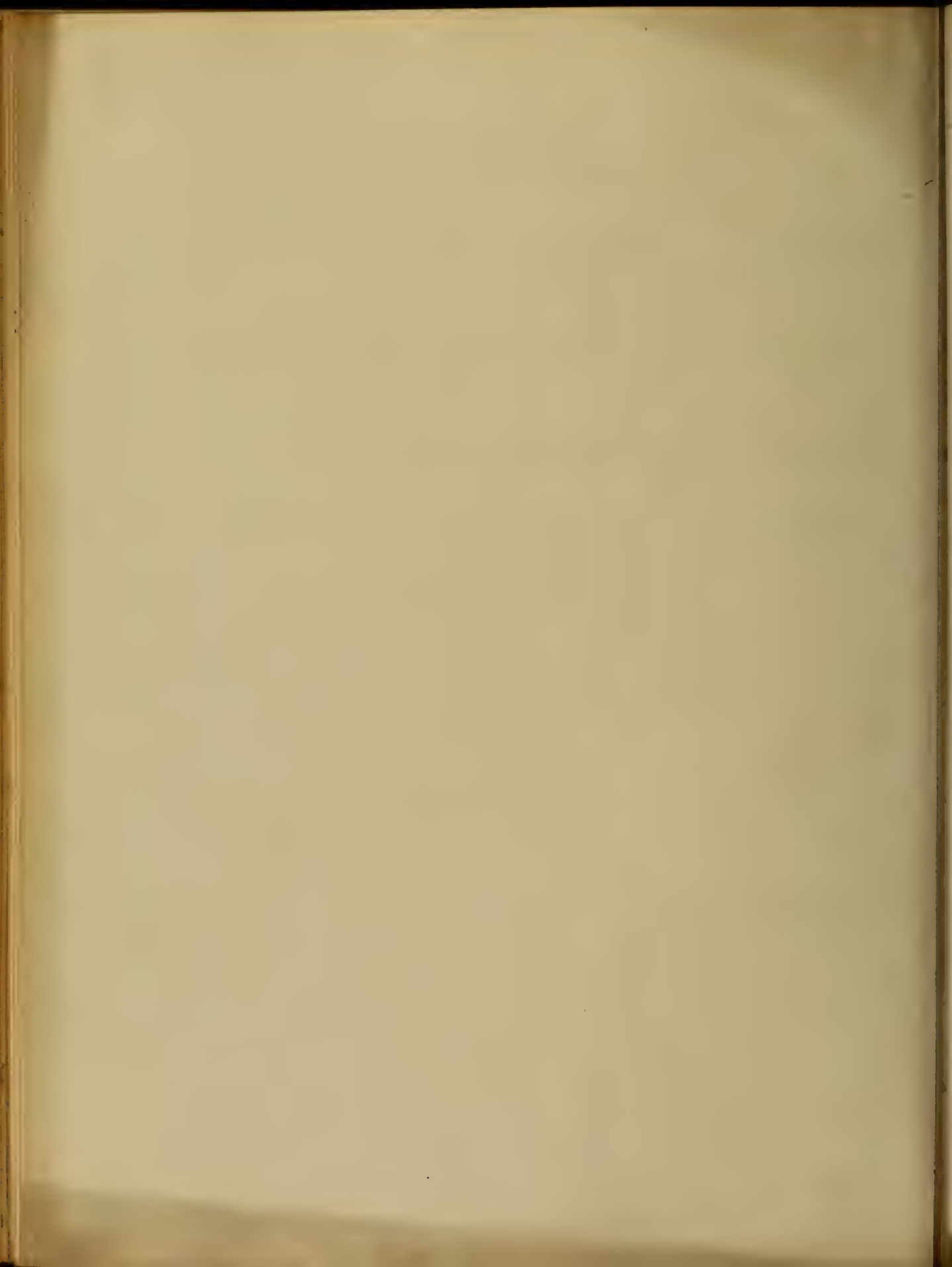
the whole being covered with
 a wide flannel cloth, the patient
 must be kept on her back with her
 knees supported by a pillow - and
 covered by light but warm blankets;
 the after-treatment in hemorrhoidal
 cases consists of little more than
 good nursing, the bladder must
 be emptied by means of the catheter
 every five or six hours and if it is
 found that the urine is the color
 of plover and limber may be given
 also small quantities frequently of
 aloe tincture, till the urine is beyond
 suspicion, but beef tea
 and broths may be given and if
 there is great exhaustion transfusion



16
must be given in small doses, the dressings must not be disturbed for at least thirty-six hours, and that daily renewing is required, the dressings may be removed on the fourth or fifth day, the abdomen being supported by a bandage across the abdomen, the patient being kept in most cases fast till the seventh or eighth day and the patient usually recovers in favorable cases, when peritonitis or septaemia supervene they must be dealt with according to their nature and intensity, the first is the most frequent and is almost always fatal in spite of any



we can do, these however are the
exceptions and not the rule. So-
thousands of sufferers are gently res-
cued from impending death and
restored to health and happiness,
thus proving the merits and the
inestimable value of the ope-
ration of extirpation.

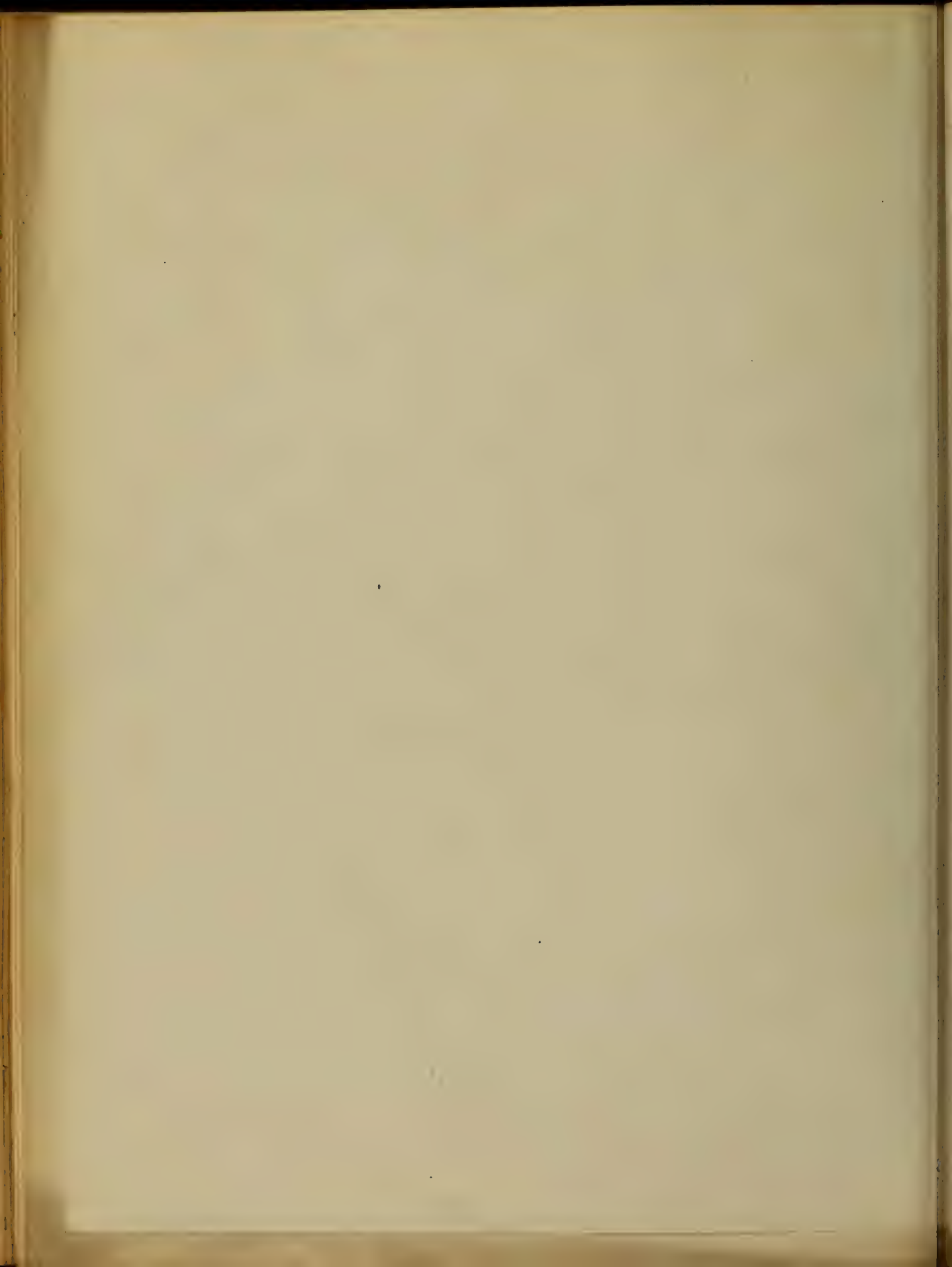


1840

Jan 1st

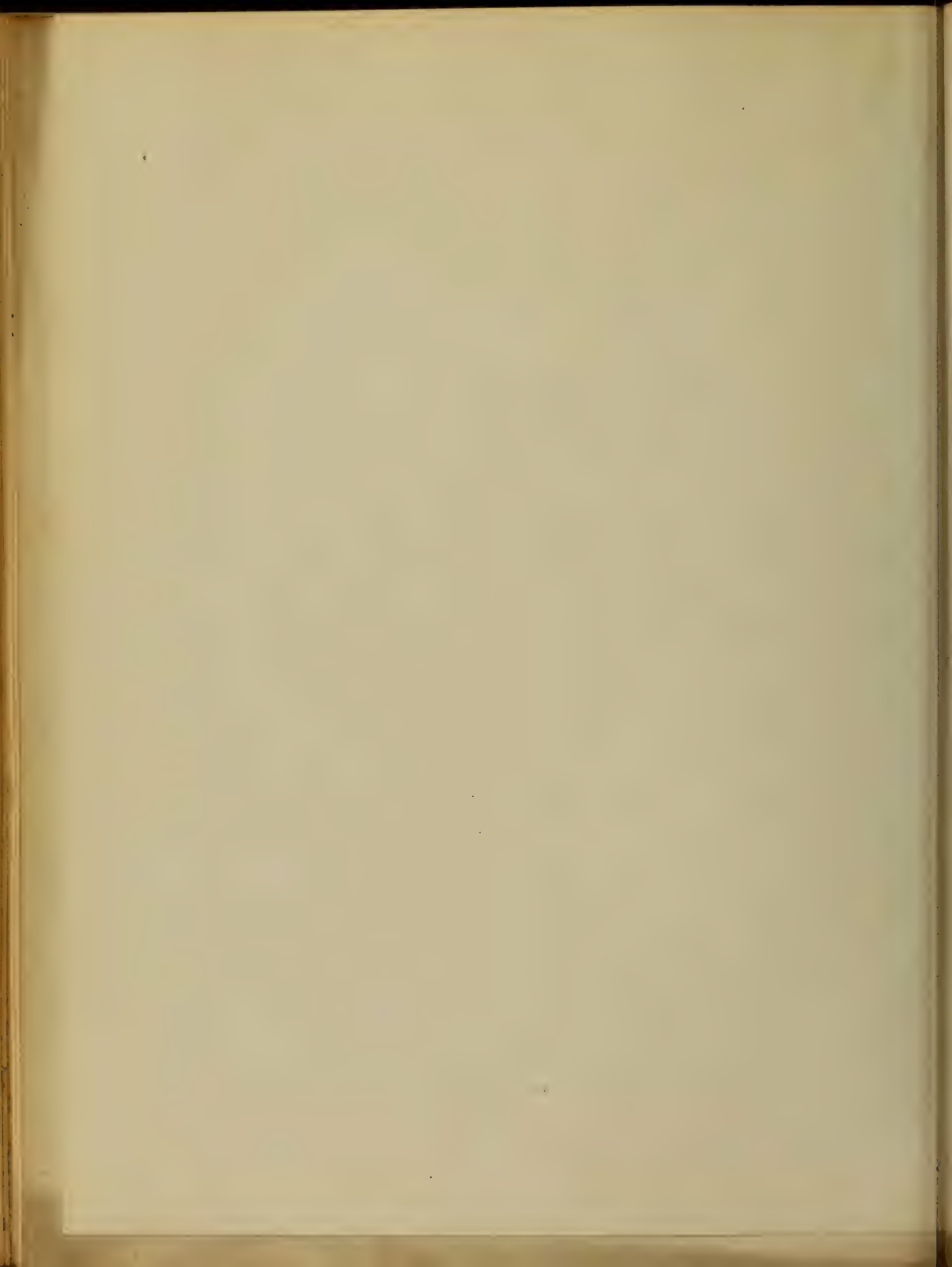
to 1st Feb

to 1st Mar

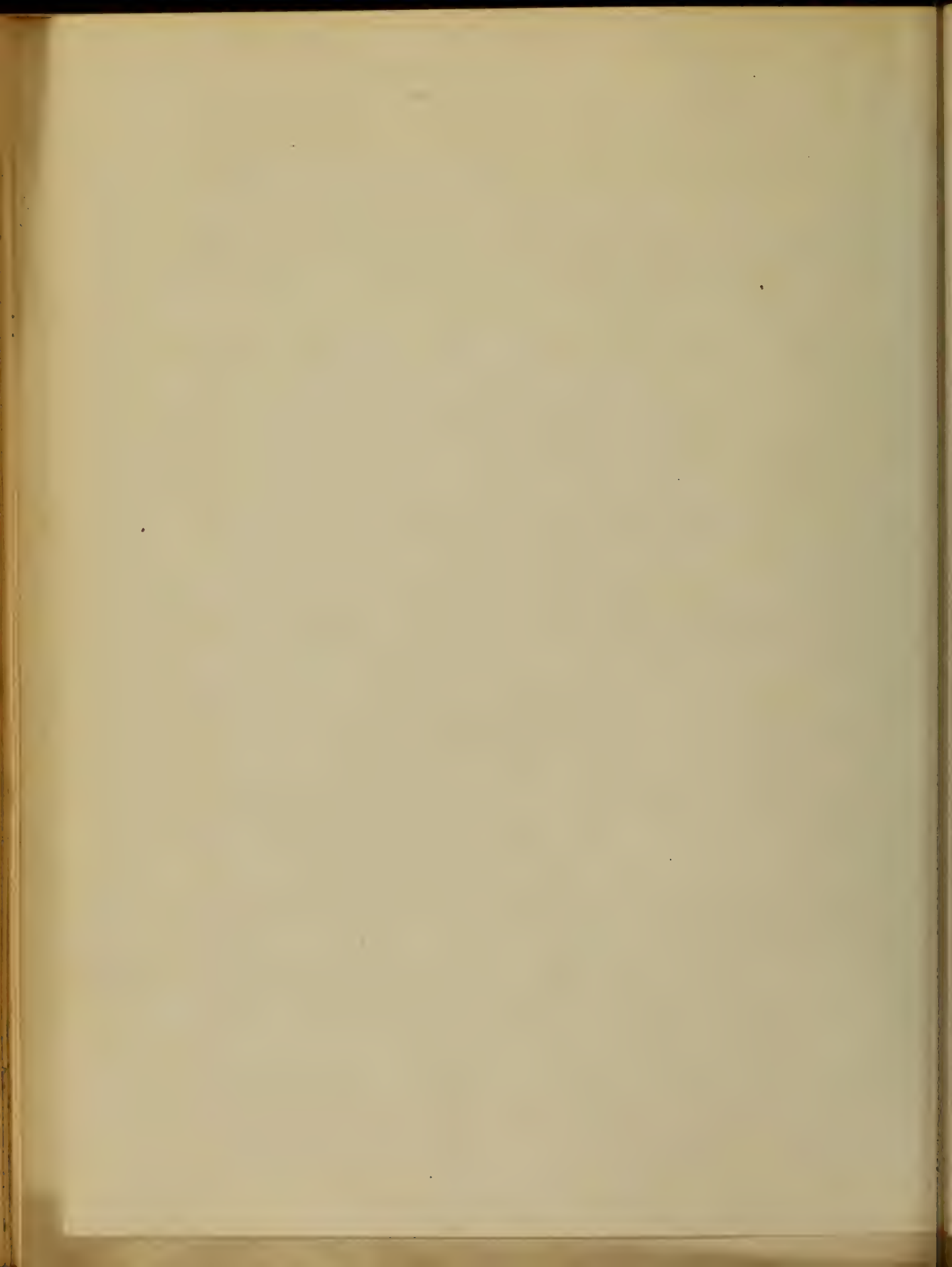


Dysentery.

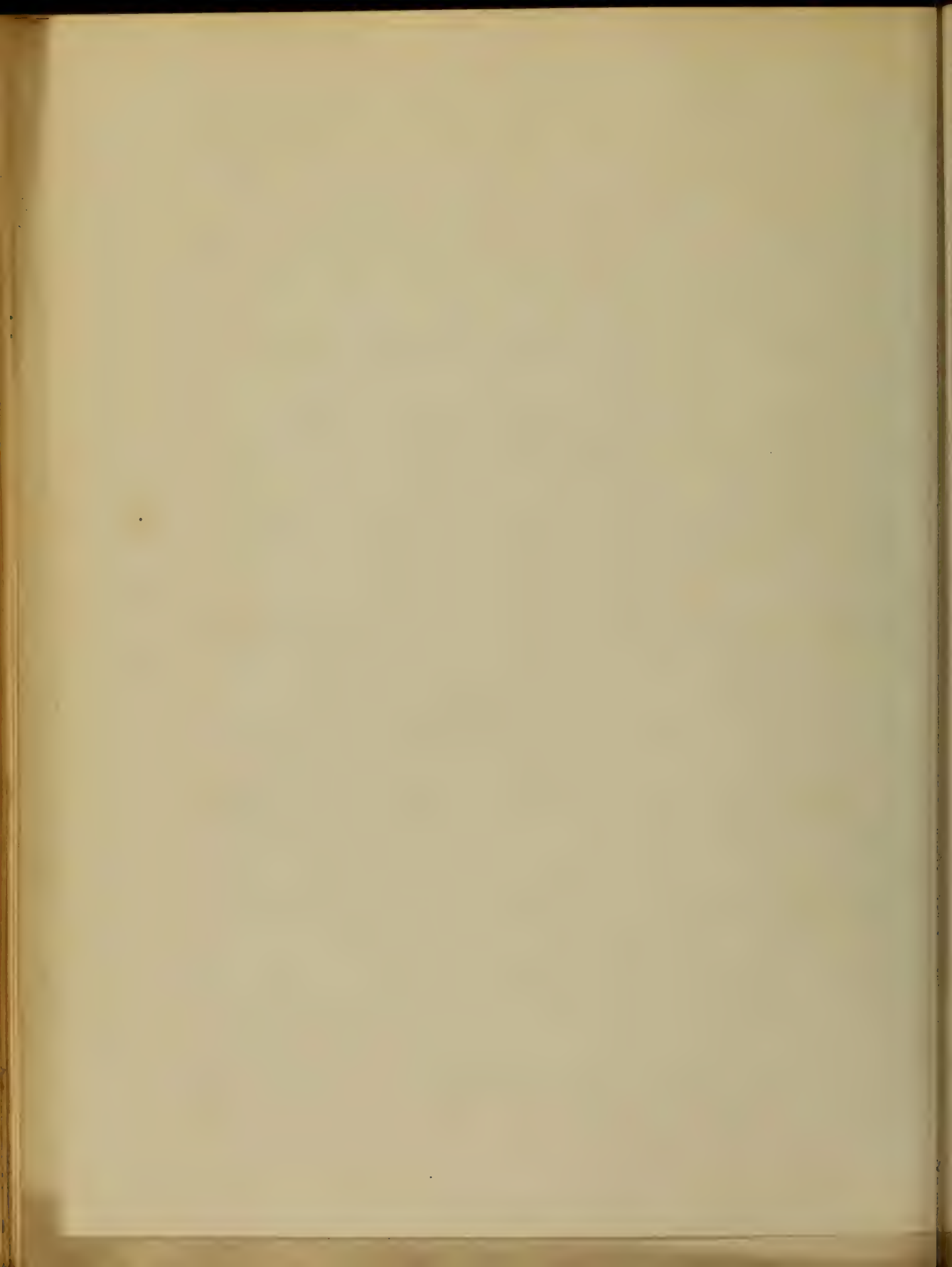
This is a disease of antiquity. Herodotus describes it in the time of Hippocrates, and it is first found in Egypt as an epidemic, and, centuries afterwards, we find it described by Aretaeus, under the name of *Malum Aegypticum*, and by Boerhaave, who calls it *Colic Dysentery*, in the year 380 of our aera. But the first known account of its appearance is in the time of Herodotus, who says it is a disease of Egypt.



prevalent in Holland in 1720, and afterwards, it is said to have appeared in several places on the Continent in the middle of the last century, it was first where it was seen and described by Marcin and Chomel. And about the same time, Ghislini describes a similar complaint which he saw at Cremona, in Italy, and is the first known description of the complaint in this country. The membrane characteristic of the disease. In this country, the first published description of the complaint, was by Dr. Samuel Bard, of New York, who published a treatise upon it, in his works, which appeared in 1771. From that date, the complaint seems to have been little noticed, until its occurrence in the city of New York in 1792.

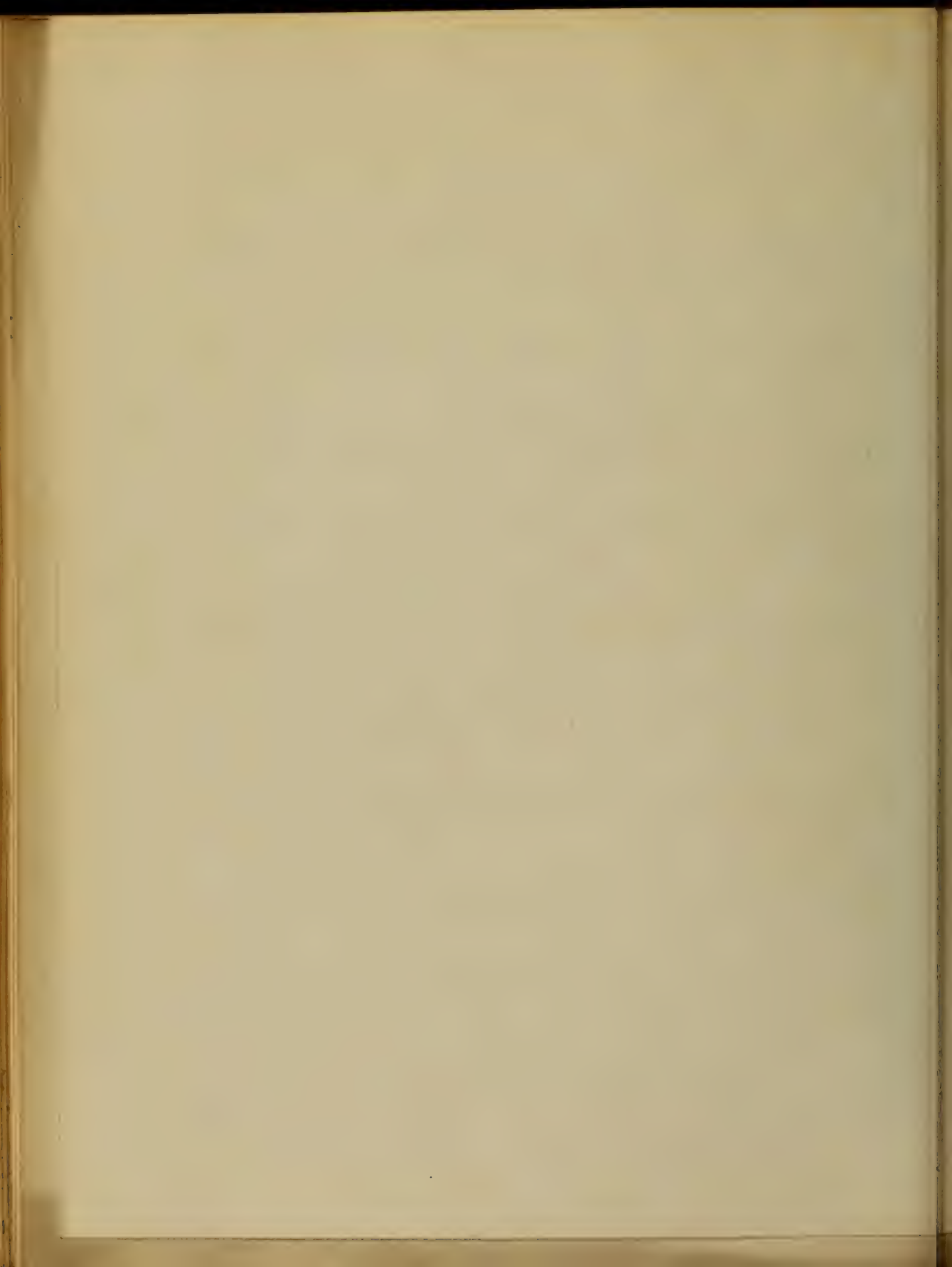


It was described by G. P. Polonskoy, of that part
of the continent, and was the first
basis of the name, and it is the
name by which, or by a derivative from it,
the affection is now universally designated.
Since that period it has scarcely been absent
from France, though especially prevalent at
certain times and places, in 1855, it prevailed
as an epidemic, in Paris and Boulogne;
In the early part of 1857, it passed over the
strait into England, where it spread quickly
through the southern counties, and almost sim-
ultaneously with the English invasion, it made
an attack upon the extreme West of our own
country, having in the autumn of 1857, it
spread in the same form in the West Indies

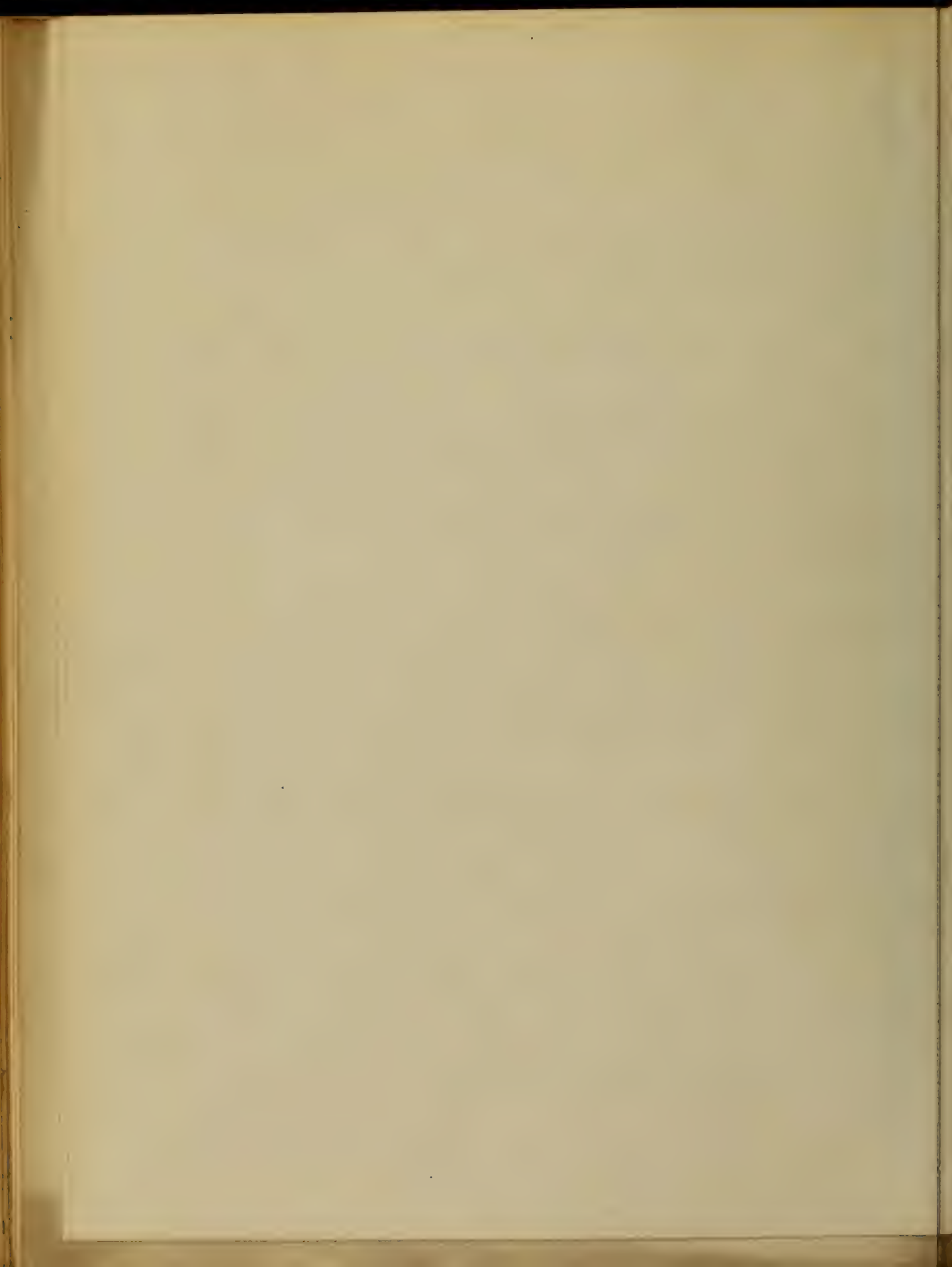


of St. Francisco in California, was first
announced and described by G. L. G. Ross
in 1817. In the Atlantic portion of the United
States it was somewhat later in its onset, sporadic
cases appeared in Kentucky as early as 1827,
but the disease scarcely assumed the epidemic
form until the year 1840, when it prevailed in
various localities over this country, and since, and
at the present time it is considered one of the most
common and fatal epidemic Maladies.

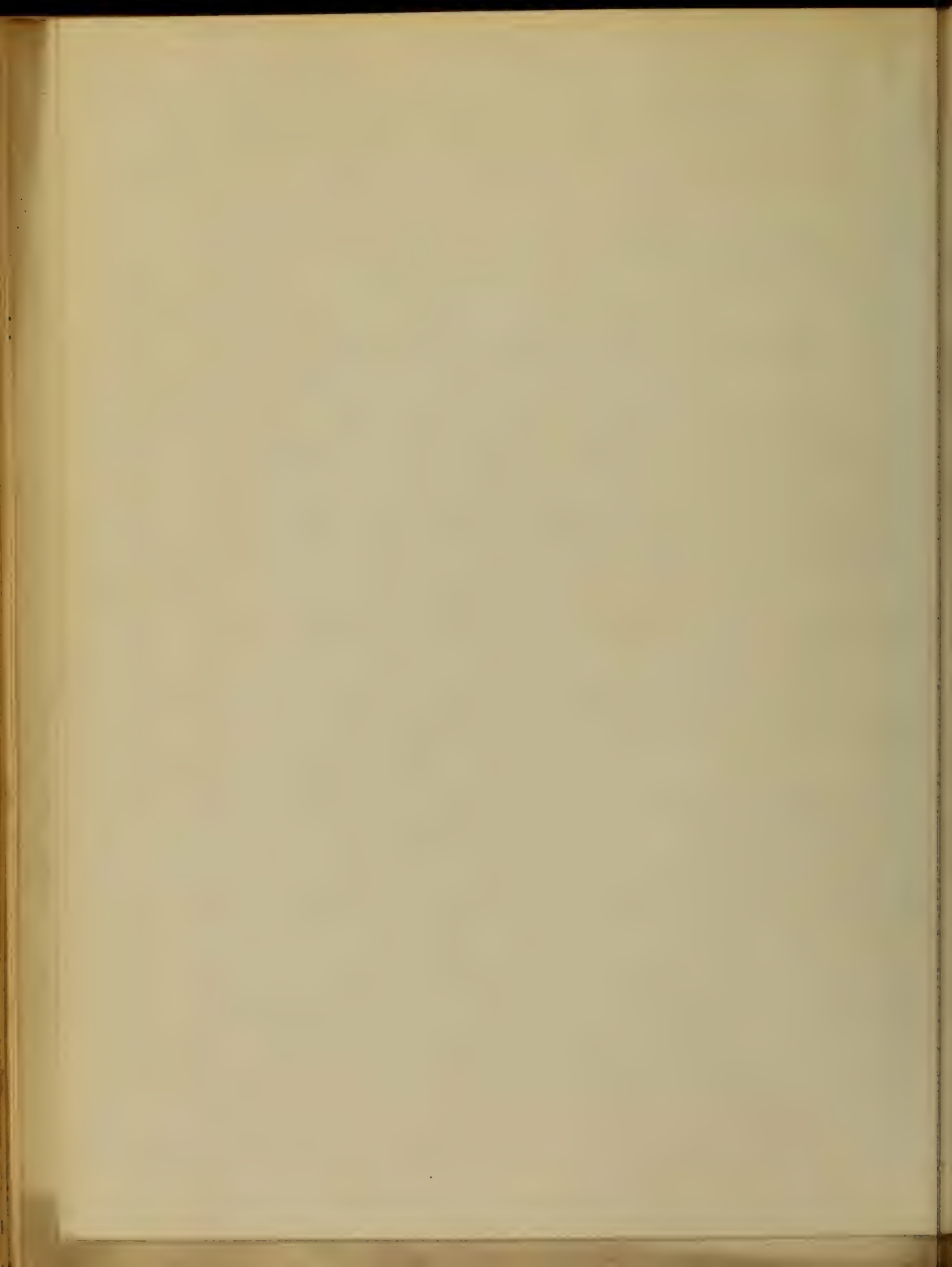
The frequent occurrence of epidemics during
the last century has been marked in the
in the present century, and it has been
a part of its cause and nature. The
the following principles have been
been followed, namely, that of



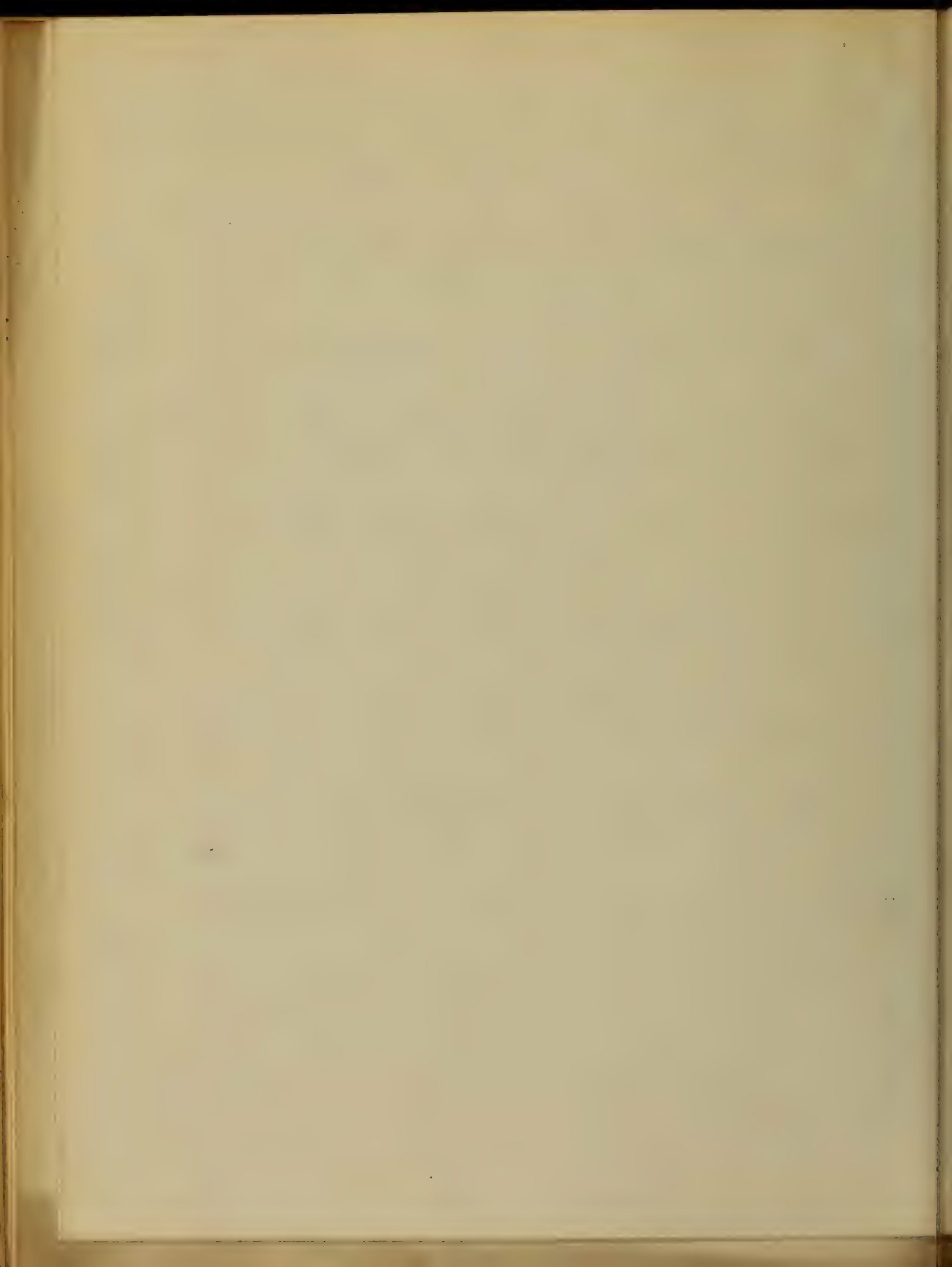
on animals, and in 1876, Dr. C. O. Walker, using a
microscope, discovered in patients afflicted with diphtheria
small spots, and with the aid of a microscope
which they appear to consist of the same
material as the spots of diphtheria found in
man. It is thought that the spots are
caused by the presence of bacteria, but only two of
them it is thought sustain a connection to
diphtheria, namely, the spherical bacterium, or as
Corti designates it, the micrococcus, the diameter
where less numerous, is the wire-like bacterium,
or A-like bacterium. There are also several
other important facts relative to diphtheria, that
in tissue, which is the seat of diphtheritic in-
flammation, and in every diphtheritic pharynx,
in most cases, the spherical bacterium is present



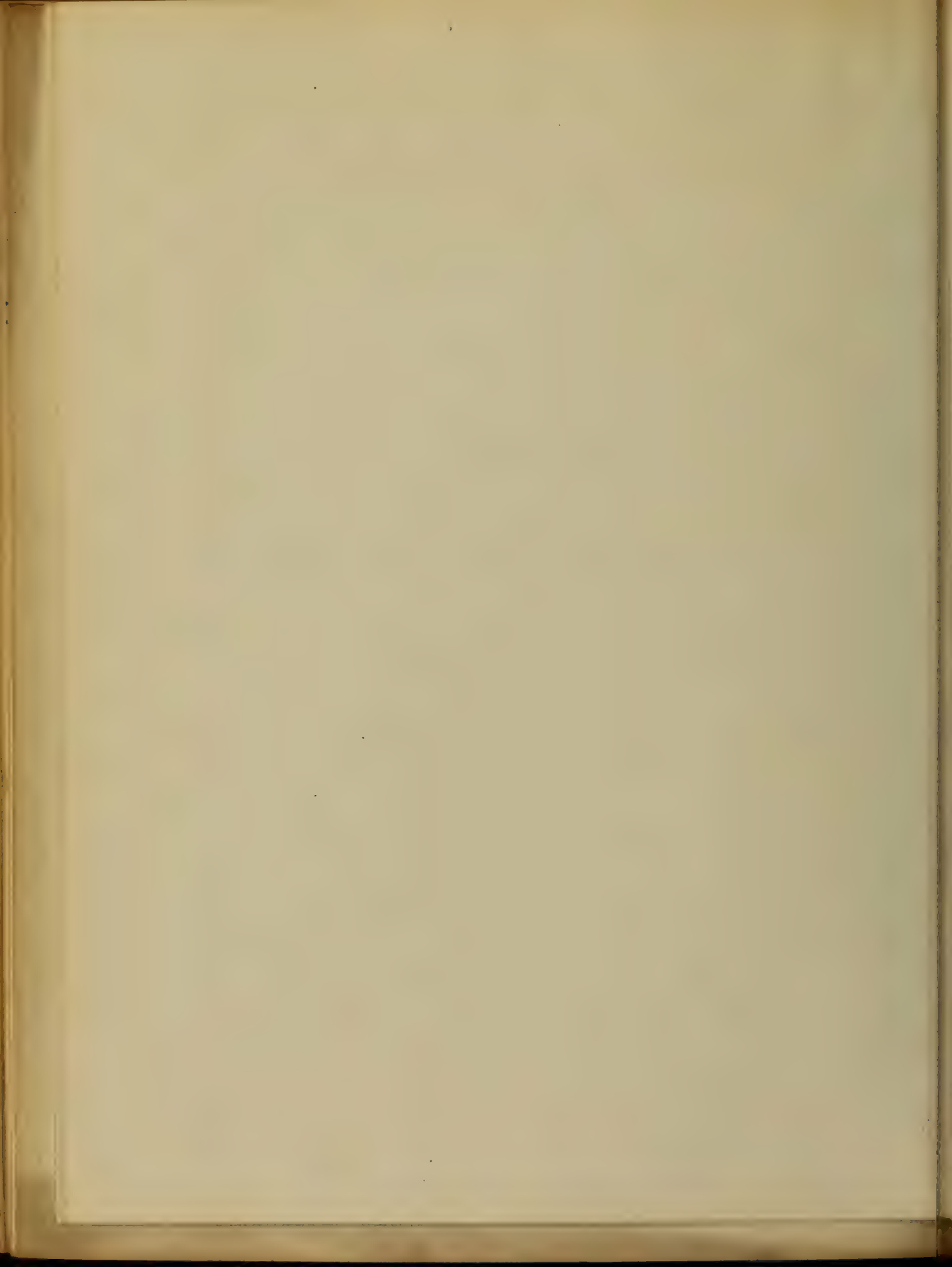
numbers, accompanied by a smaller number of the
other variety. In severe cases, in which the system
is injured, the number of bacteria is small,
as the symptoms of diphtheria become more grave
the number of spherical bacteria is small, in pro-
portion to the tissues and epithelium in contact
with the diseased system. Cullen, according to
his experiments, the bacteria found in the
mucous membrane of the throat, but the bac-
teria, found especially in the granular
tissue, were taken up by the blood and passing
over their tissue, they give the blood and
consequently, and being about in a bacteri-
oid way, a denuding of the fluids, and in
consequence, serious eruptions. But the cause and
nature of a disease cannot be fully understood
by experiments alone, they would be aided by



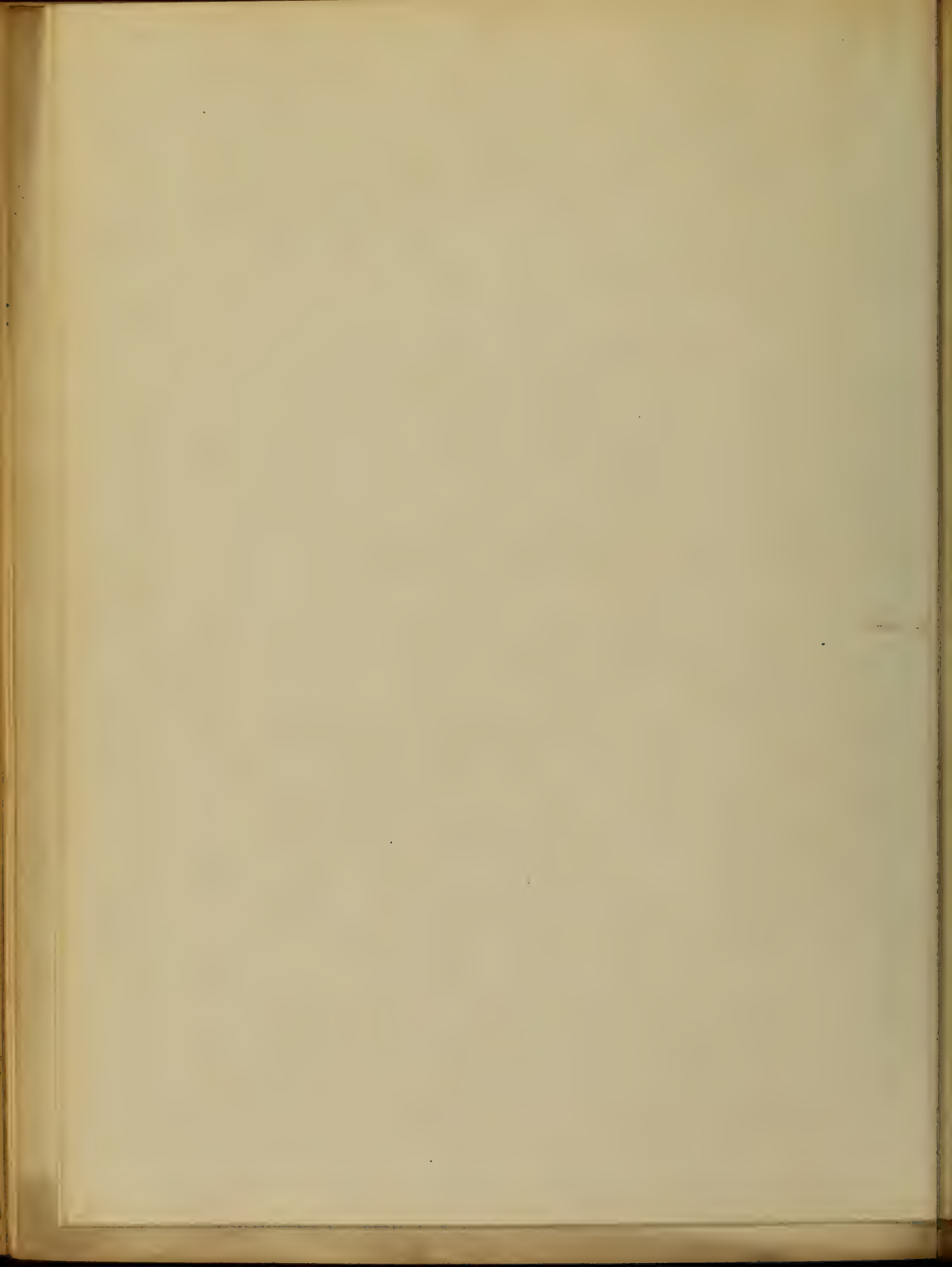
clinical observations, yet the importance of some
experiments cannot be too highly estimated.
It is considered that diphtheria is a disease which
in most cases appears primarily and chiefly upon
the fauces and nasal mucous, is that the virus
which contains the germ of the disease, and
passes over these surfaces, and, as regards the fauces,
the virus is the virus of the disease, and
the important practical inference from this theory
is, that diphtheria is not contagious, but is transmitted
in the same manner as the virus of the disease, and
any theory which regards diphtheria as a virus
transmitted in this manner, will not be
accepted by the profession in general. Although it
is possible that in some cases, as in the case of
others in which from the severity of the initial symptoms
and the little amount of virus, the



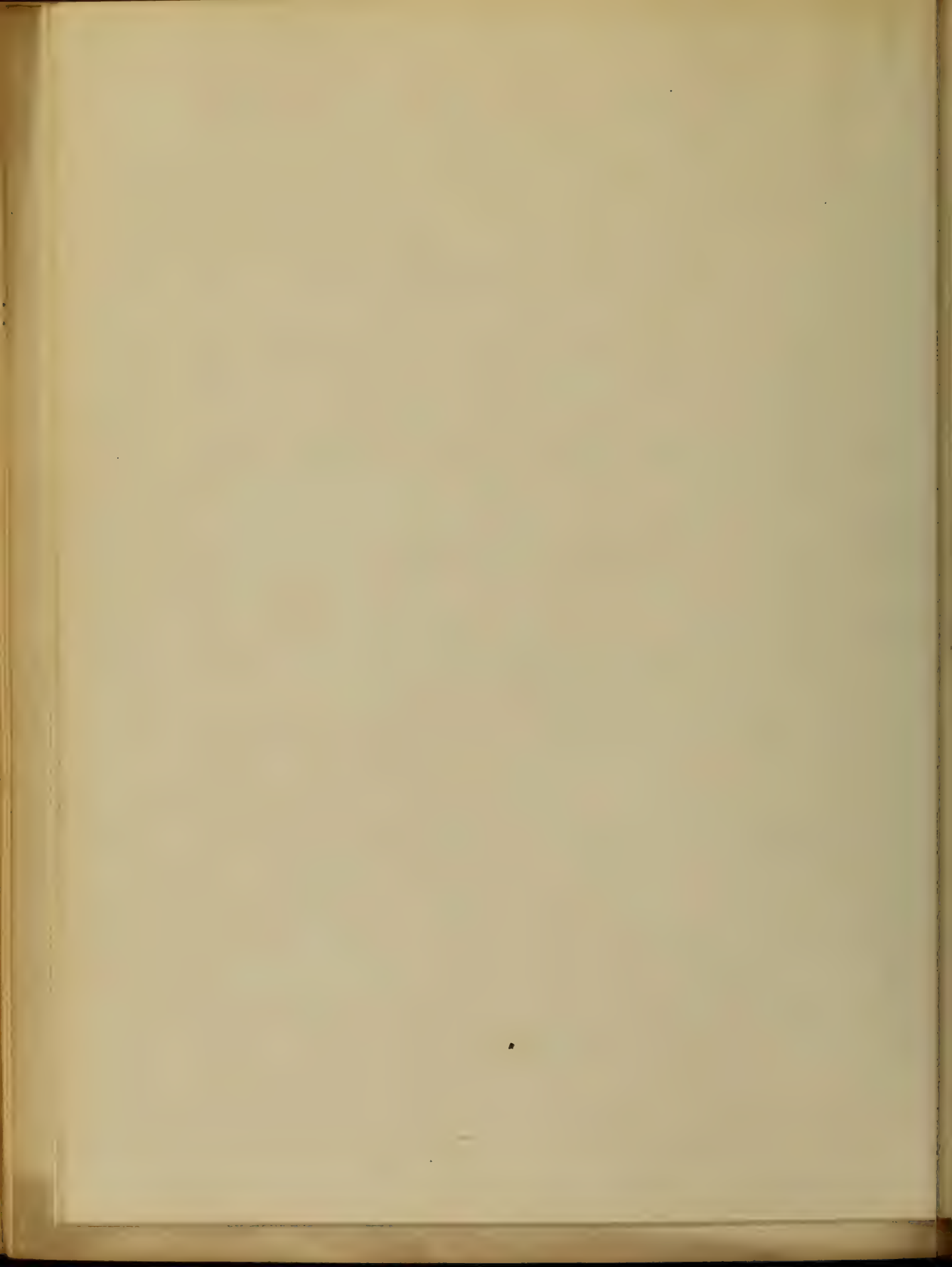
is very rare to suppose that the blood
is not the source of the disease, but
the belief that diphtheria is in certain cases a
constitutional malady in its commencement,
while in others, probably in most cases, it is
merely local, and subsequently constitutional, has
been the great source of error. It is in most
cases, in fact, local, and the admission that the
disease is constitutional is a step towards a
restoration of the disease. But while we are
and support to the evidence that, in the
fact, there must be a constitutional
of diphtheria which is distinct from the local
the following are some of the principal facts which
the theory, in the treatment of diphtheria, and
in which the local diphtheria is not cured. The
microscope discloses the existence of bacteria, again such



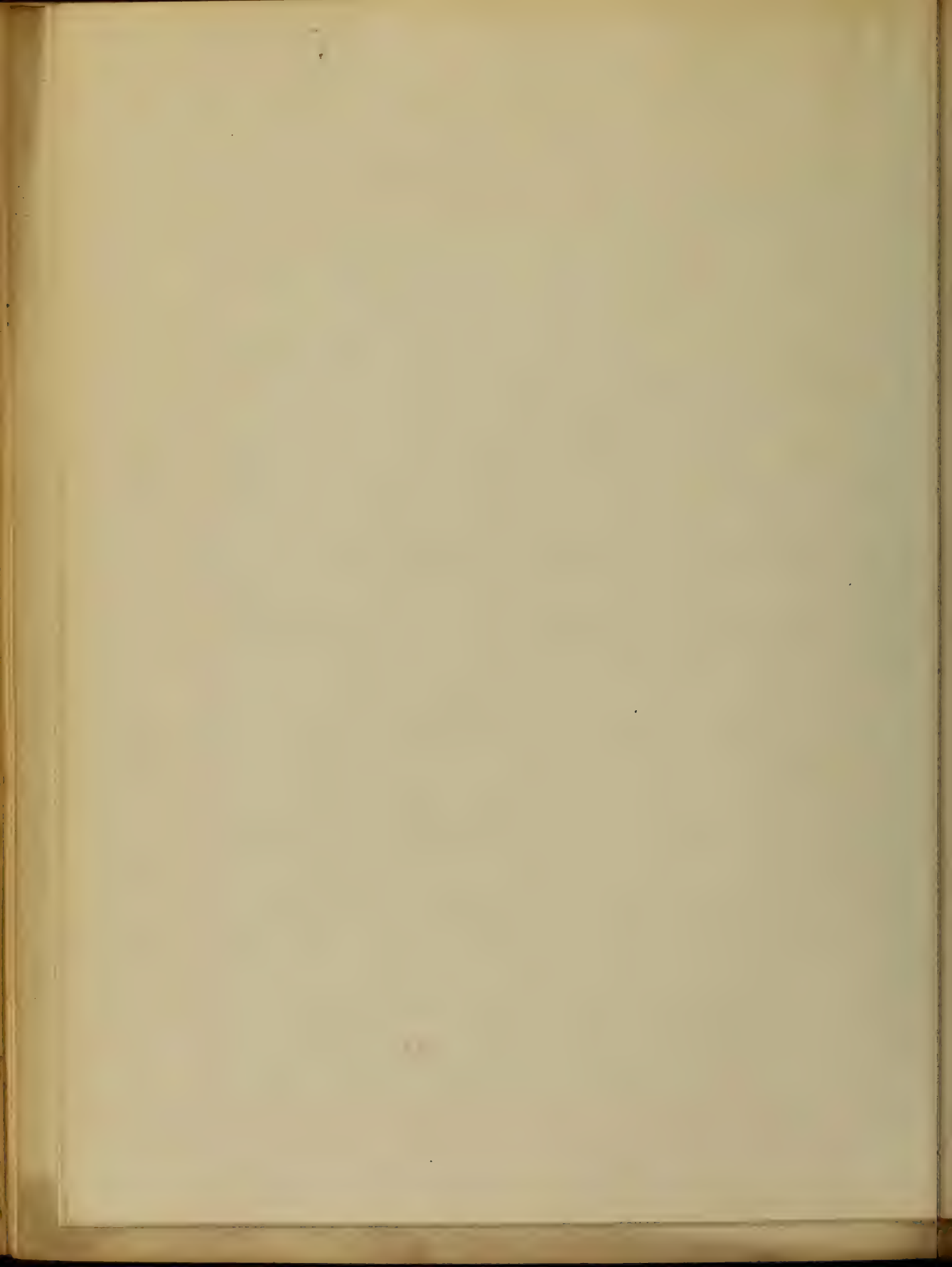
which seem to be identical with those frequently found upon the gums below the heart, where they produce no specific effect. And an other fact which, till it is explained, produces skepticism; why do they not irritate the lining of the respiratory tract, when they are along in the current of air, are arrested upon the fauces where they produce specific inflammation, a large number must enter the lungs, where we would suppose, from the delicate structure of these organs, they would produce inflammation, which is the complication of diphtheria. It is evident, that the true causation of inflammation which is diphtheria lies in one of two hypotheses - either these parasites, are the specific virus, and therefore cause the disease, or that the cause is something more subtle not yet discovered, which so acts the



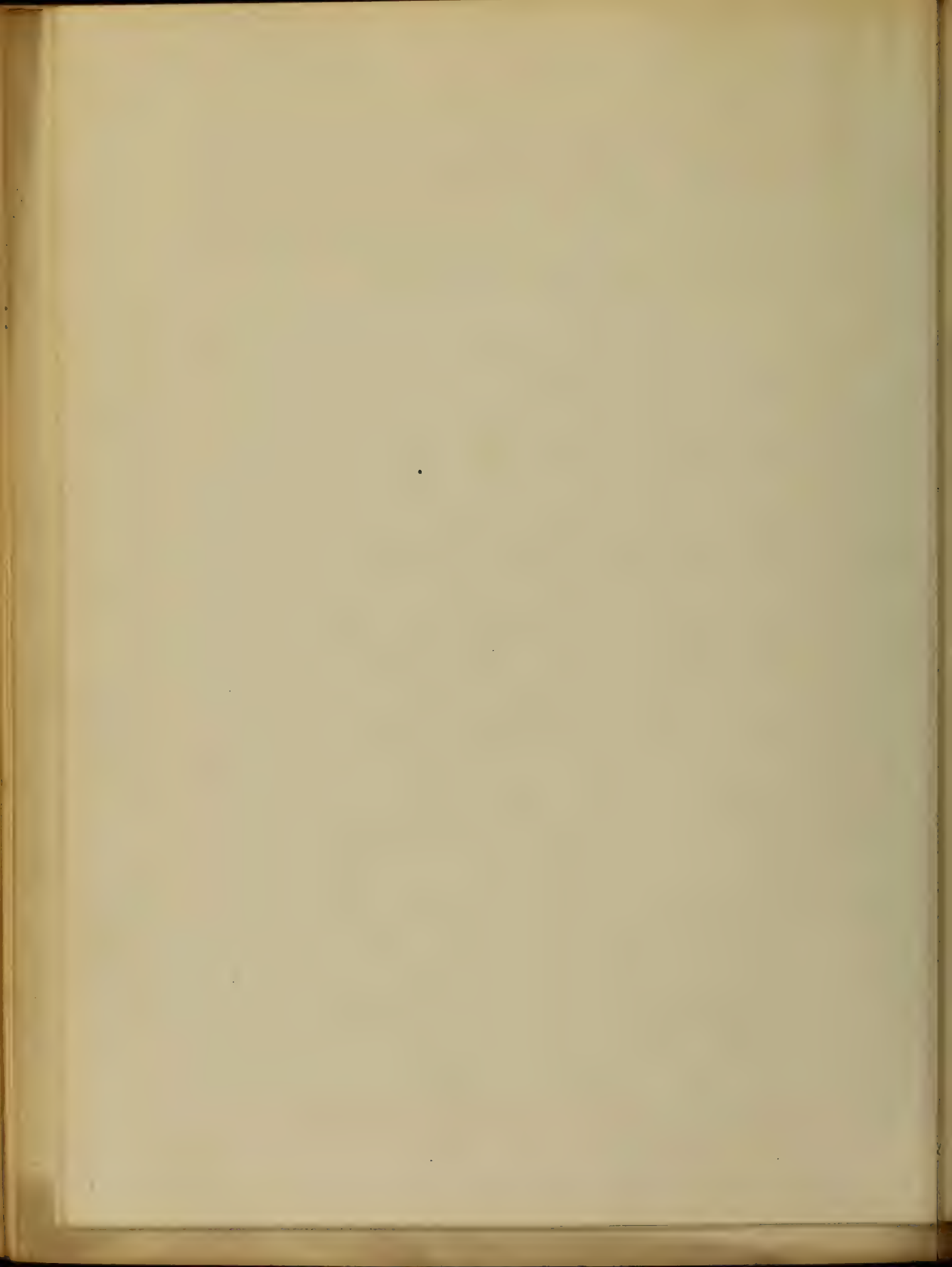
lissus and the wood that lie
in which the epithelium is greatly thickened
The commencement is redness of the fauces, with more
less swelling of one or both tonsils. There is an
opacification, which is at first thin and transparent
parent, becomes opaque and more or less thick
The lymph is deposited successively in various forms
in a stratified thin membrane, which is white
and dense, sometimes different points of perforation
are observed, which stand out and call attention to the fact
that the fauces are almost entirely compressed, and in
the pseudo-membrane is more attached to the
mucous surface, which it perforates. Although the
days, decomposition commences, and that which
was at first formed, becomes after than the
more recent production, when this covers the



color of the eruption changes from a whitish
or a grayish white to a dirty brown, and its
exposed surface is uneven and jagged, and the
edge present well defined, though sometimes pro-
ducing an appearance very much like that of
an ulcer. Different cases differ in the extent of
the eruption within the jaws. The eruption
may extend over the posterior part of the jaw,
the eruption within, and forward over the whole
part of the soft palate. Scarce a trace of life
be perceived in these surfaces is to be
seen. The eruption sometimes takes place in
three or four days, and is sometimes limited
to twenty days, and not infrequently it is
limited by a second and sometimes a third
and even a fourth formation of a false
membrane. The eruption of the neck and

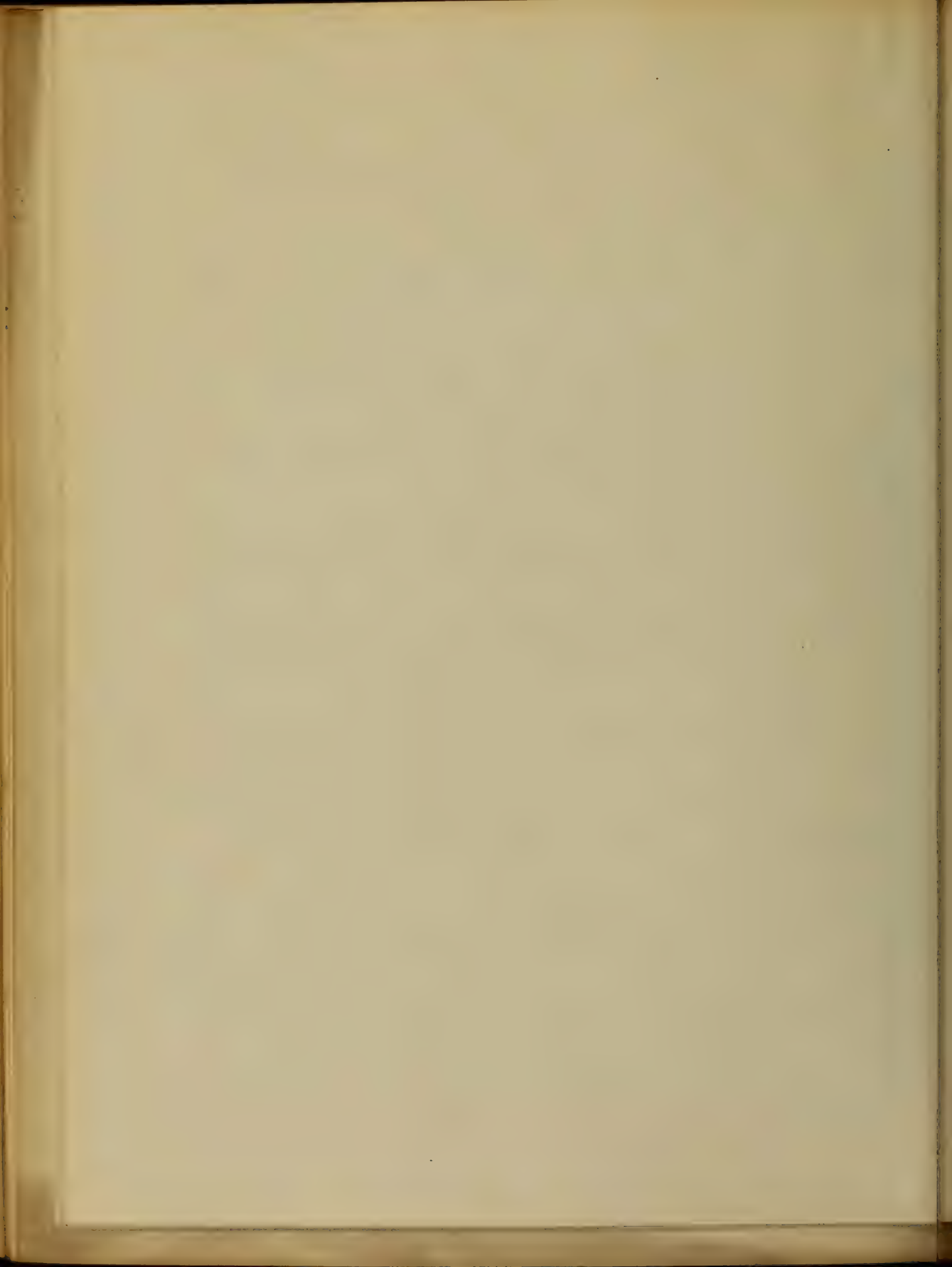


especially those behind the angle of the
jaw, are more or less enlarged, painful and ten-
acious in the great majority of cases. Also with the
enlargement corresponds with the affection of the
in the throat. The virus runs the same course
itself, locally in the faces alone, but in cases of
more acuity and longer, the affection extends to
other situations. The sores, both anterior and
posterior, on one or both sides, and sometimes
the cutaneous test is involved. The
membranes of the throat and of the
present patches or be successfully coated with
false membrane. The eye is sometimes invaded
causing impairment of vision for a short time
the reason. The parts communicating with the
faces are not the only parts liable to be affected
in cases of diphtheria. The vesicles of the

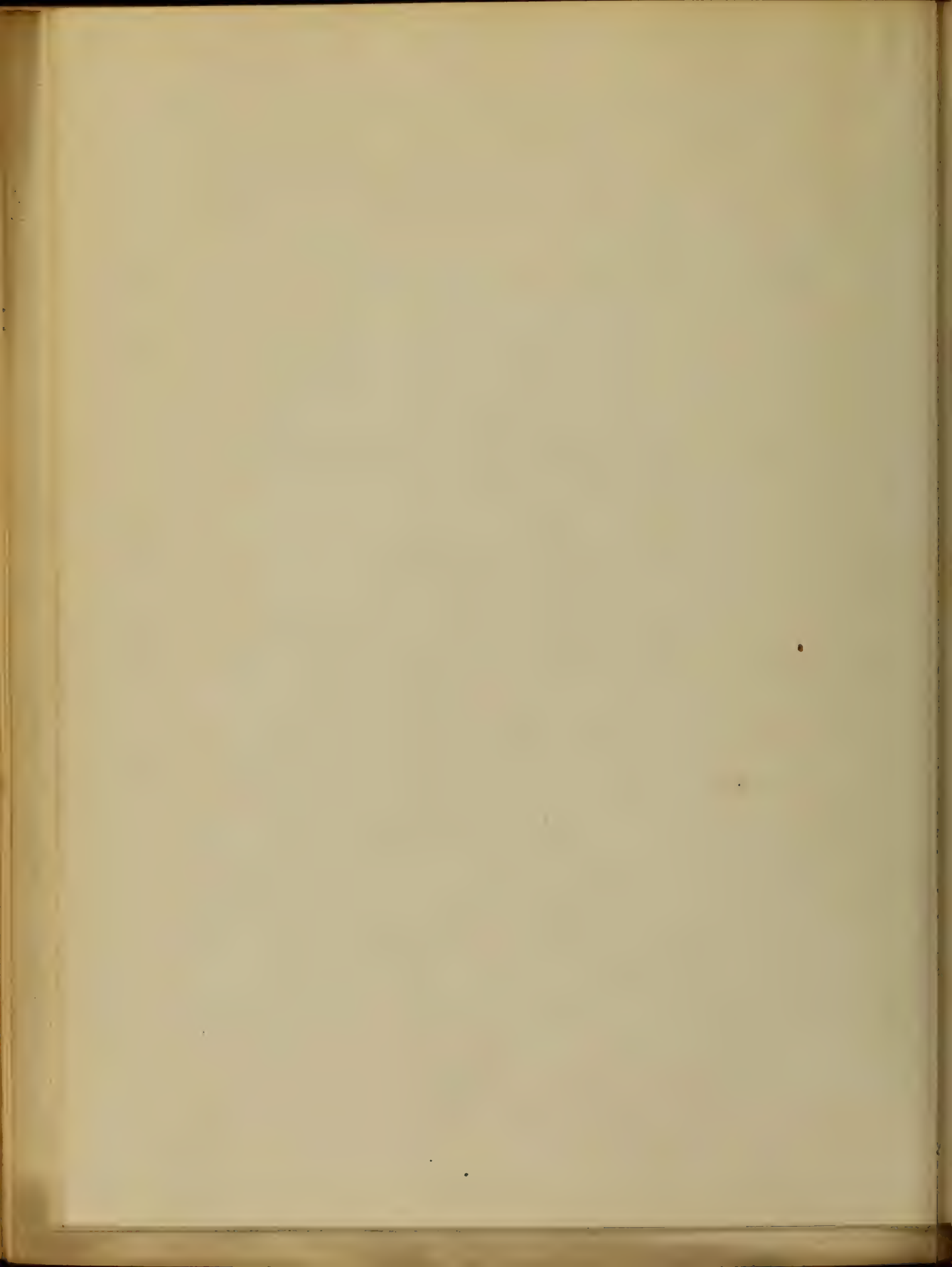


...the lungs, the liver, and spleen
sometimes affected. The circulation also appears
in some cases on the skin in parts elevated,
in irritated impura. In such cases, in short, when
the skin is deprived of the epidemic.

As with other contagious diseases, the
symptoms vary greatly in intensity in different
cases, the general in the commencement
of an epidemic. In the first is more common and
fatal, and its symptoms more violent, than
when the epidemic influence is abating.
The symptoms in the commencement are
often mild. There is a degree of chilliness,
with rigors, often slight but lasting several
hours, which is succeeded by increased heat,
thirst, hunger, and loss of appetite. The
patient continuing to walk about, as if

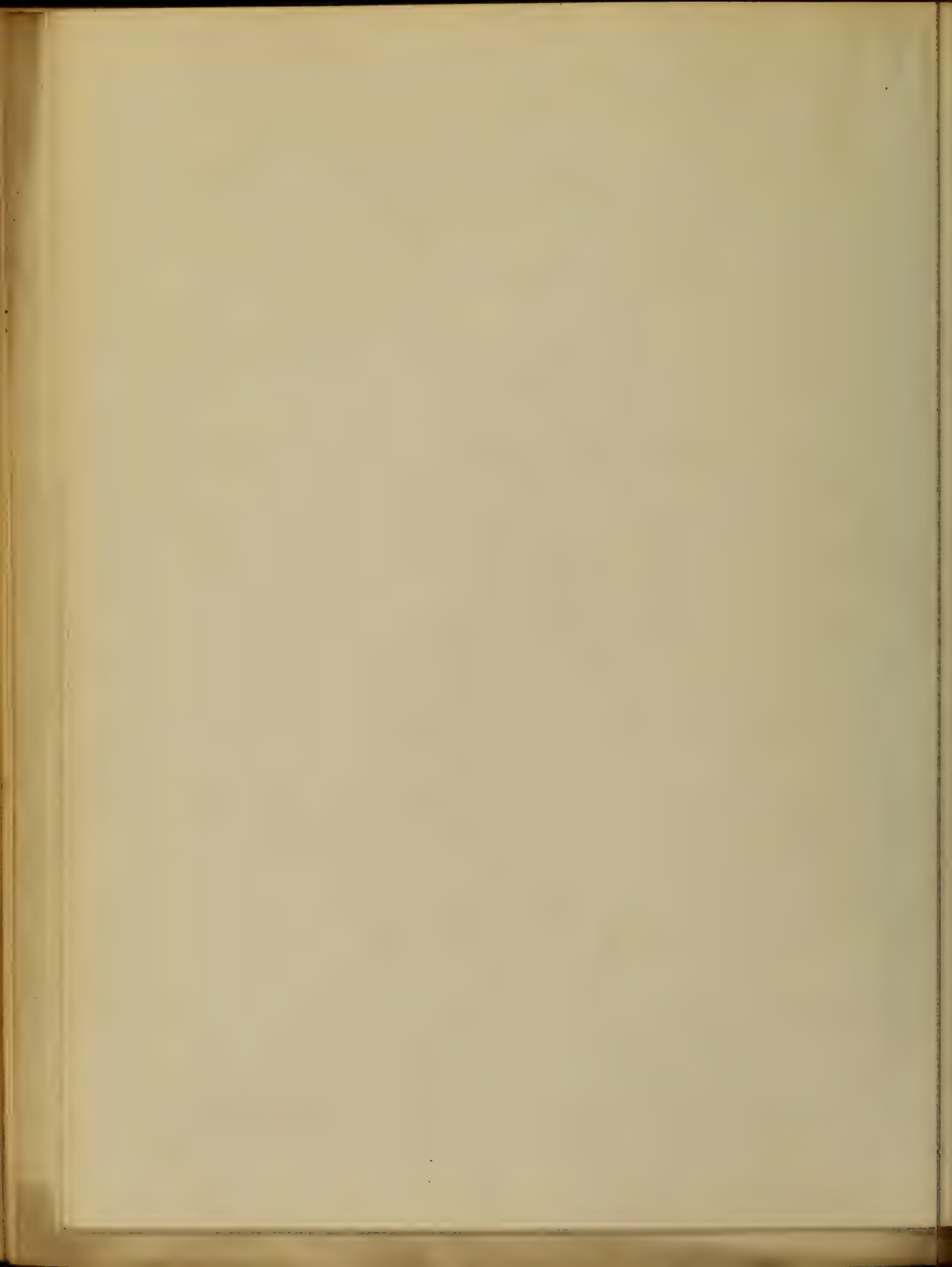


affected with a severe cold, for which the
initial stage of diphtheria is often mistaken.
In other cases the invasion is more abrupt
and worse, great febrile action, head ache,
pain in the ear, aching of the limbs, and
loss of strength, render the patient liable
to end from the first. Inflammation is
present, but it is unusual. The tongue is covered
with a moist fur, sometimes more or less of
the exudation appears upon it. The appetite
is poor. The pulse in different cases varies
greatly in volume and frequency, it is often
full and strong in the first days of the dis-
ease, but in the latter part, when death from
blood poisoning approaches, it is feeble and slow.
At first there are no marked symptoms
applicable to the respiratory apparatus, but

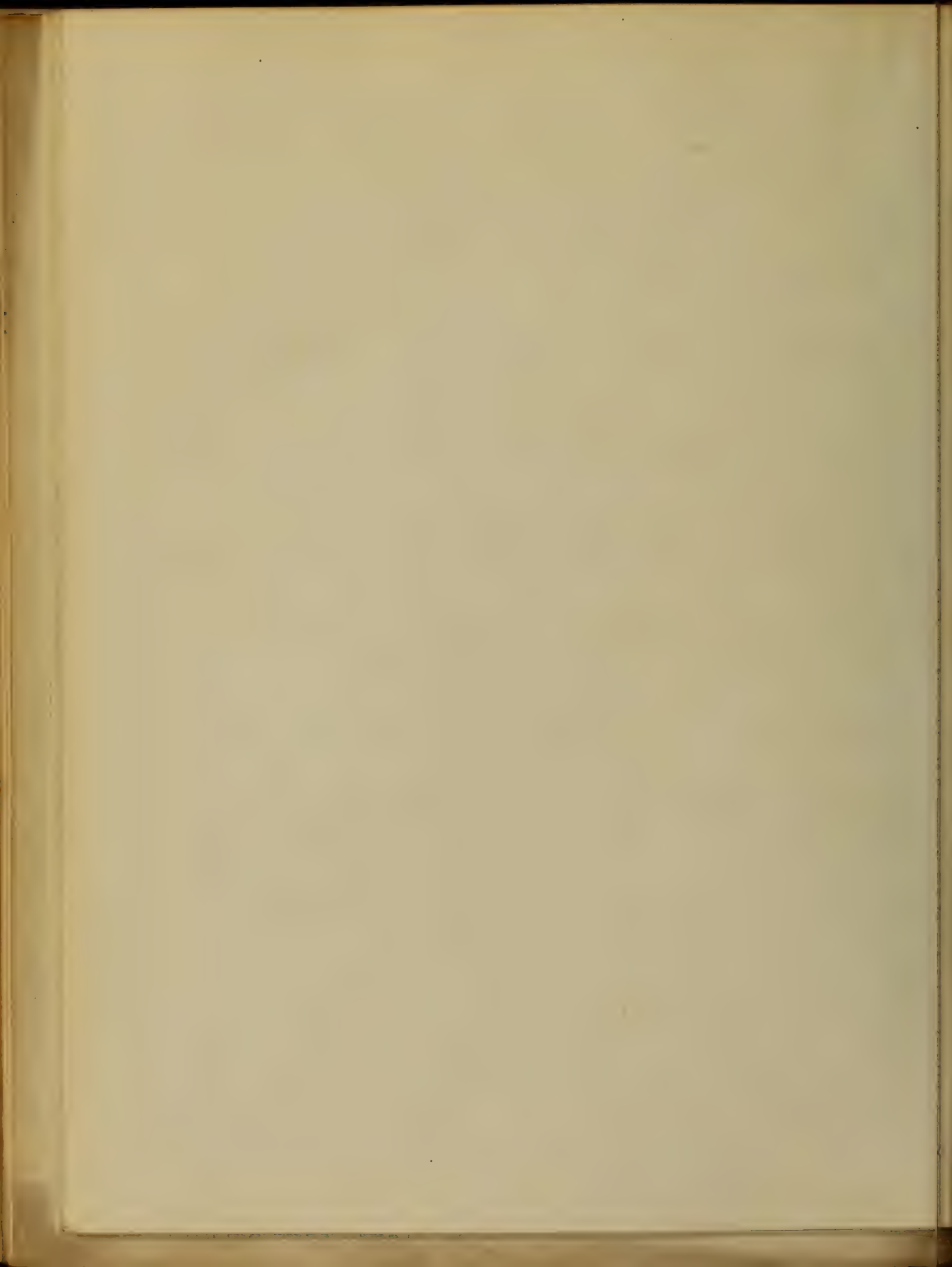


in the acute stage of the disease, the
inflammation is local, and the
inflammation is of a purulent
The presence of the local inflammation
the symptoms are hoarseness of the voice and an occasional dry
cough. In severe cases the breath is ordinarily
difficult, and the patient is unable to
speak. The disease is distinguished from
diphtheria by the absence of the
membranous exudate, and the
absence of the local inflammation of the
throat. The disease is usually
self-limiting, and the patient recovers
in a few days. The only liability to error, is the
confusion of the disease with
secretion in some cases of pharyngitis.

As regards the prognosis of diphtheria, it

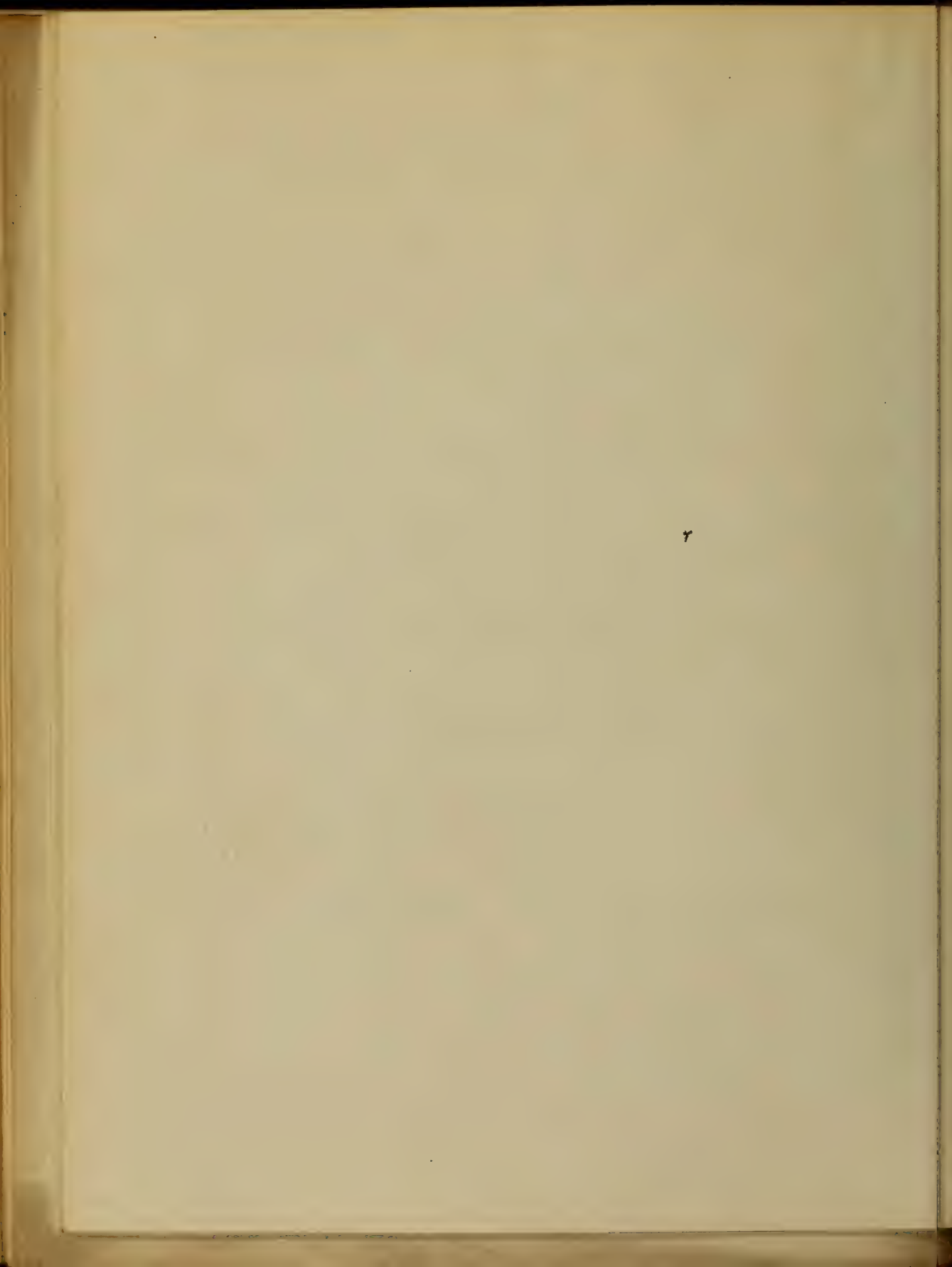


is more severe at the ...
than when the epidemic ...
wailing its severity is in a ...
part of the ... symptoms ...
is from an invasion of the larynx, the case
in which the air passages become involved the
most ...
or contributes to the fatal results whenever the
larynx is involved. The danger is second
from Asthenia or exhaustion. The violence
of the disease may destroy life within forty
eight hours from the date of the attack. In
cases in which the disease is ... the
prognosis is ... the ...
and ... from the ...
posterior and anterior nares, or if it exist
abundantly in other situations. Other

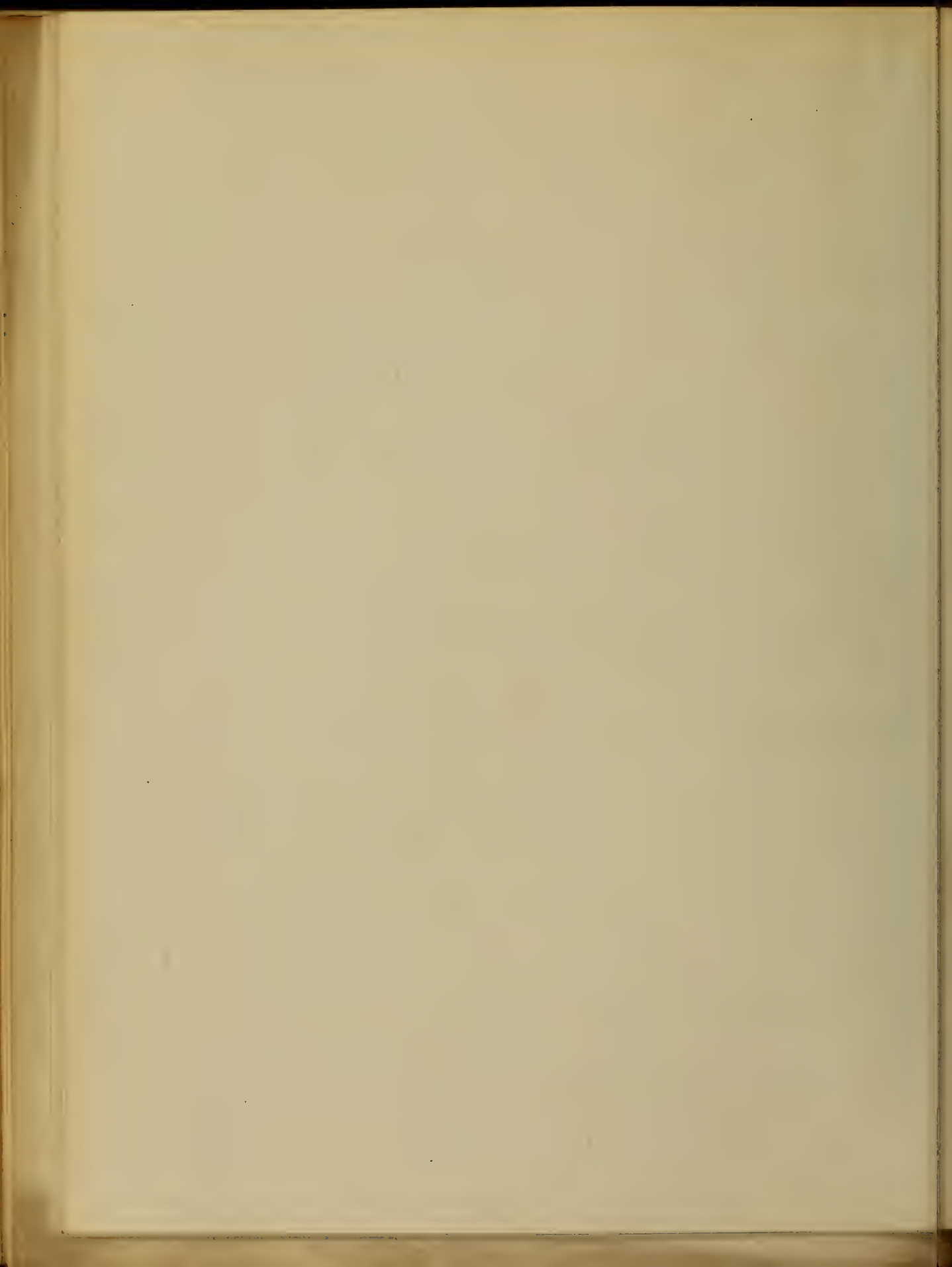


other situations, great frequency and febrile
of the pulse, and the presence of
albumen in the urine, convulsions
delirium, and coma. Yet always bear in
mind the important fact that it is to
be sought out at its source in the liver.

With reference to the treatment in typhoid
It is obvious if the views expressed in regard
to its pathology are true, that the most typical
treatment of typhoid is of the utmost impor-
tance, since essential factors, that the result
of this remedy is in most instances propulsive
to its more manifestations, at least in the
commencement of the disease. Now if by our
treatment, we can limit the exudation to a



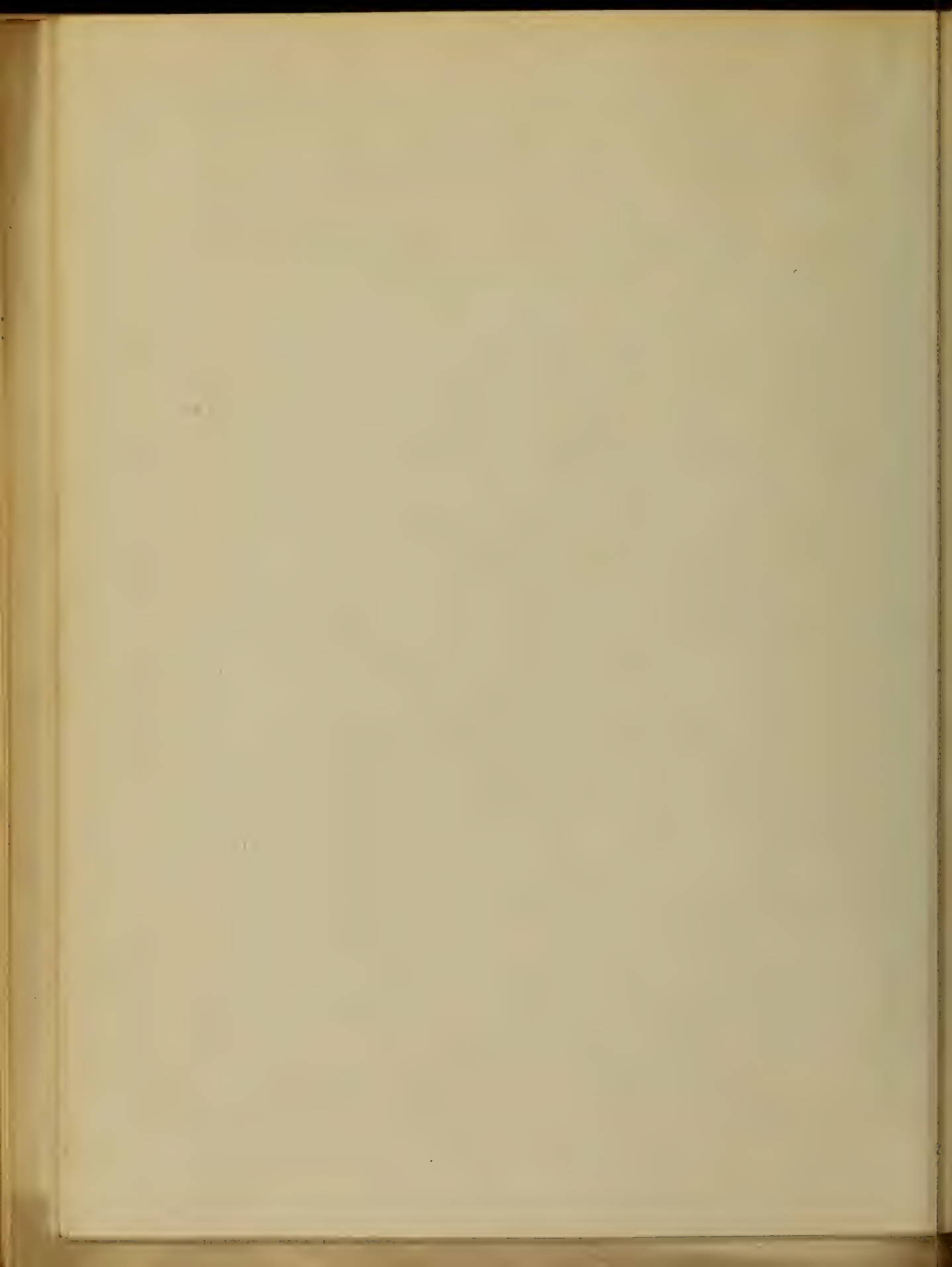
surface, or remove it at an early stage.
The patient is probably said. Prompt treatment
of the disease of the mouth is the
first step is to not delay in the
possibility of converting the disease into that fatal
form of typhoid inflammation, usually the
Larynx. In some cases the typhoid inflammation
which is now apt to accompany
such treatment, if the inflammation is acces-
sible, is the prevention of food poisoning. Last
treatment should not be painful. It is advised
not to attempt to tear off the membrane, for
its forcible separation irritates the inflamed
surface, and produces hemorrhage, and
disinfecting substances on surface should
be applied in such a way that it penetrates
the, such as mercury. The application



should be made with a camel-hair pen
It is less irritating, and affords a greater quantity
of liquid to the fauces. As soon as the case comes
under observation the following mixture is
recommended by Robt. W. H. Howard to be ap-
plied every two or three hours, over the fauces.

R. Laud. castelic ℥ss
Sij. ferri subsulphatis ʒj
Chlorine ʒij

If there is discharge from the nostrils
indicating a slight catarrh inflammation a
little or two same mixture diluted with
an equal quantity of warm water instilled in
each nostril every four hours will be very
beneficial. Quinine in doses of two to five
grains according to the age and severity of
the case, is administered about every four hours

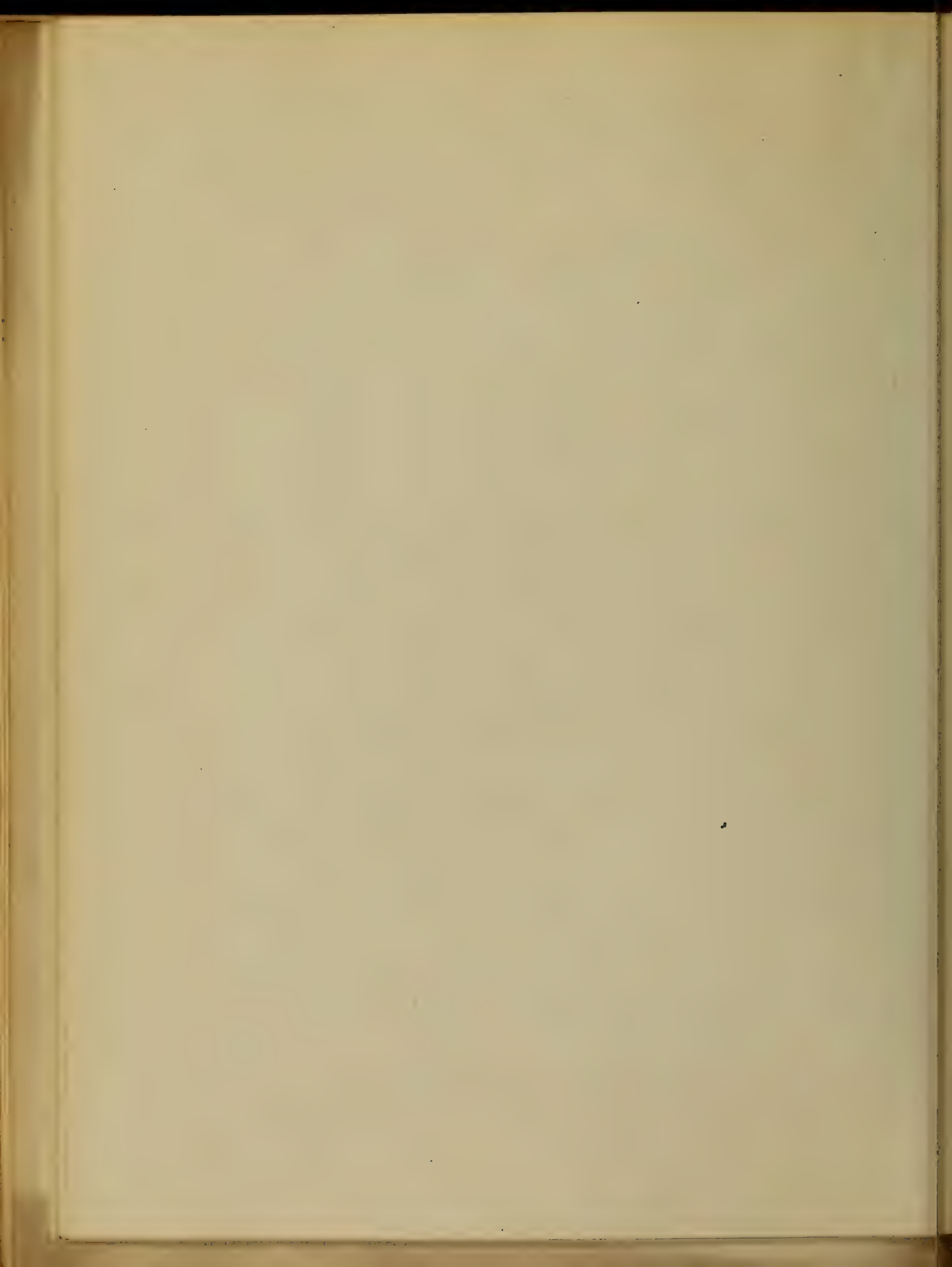


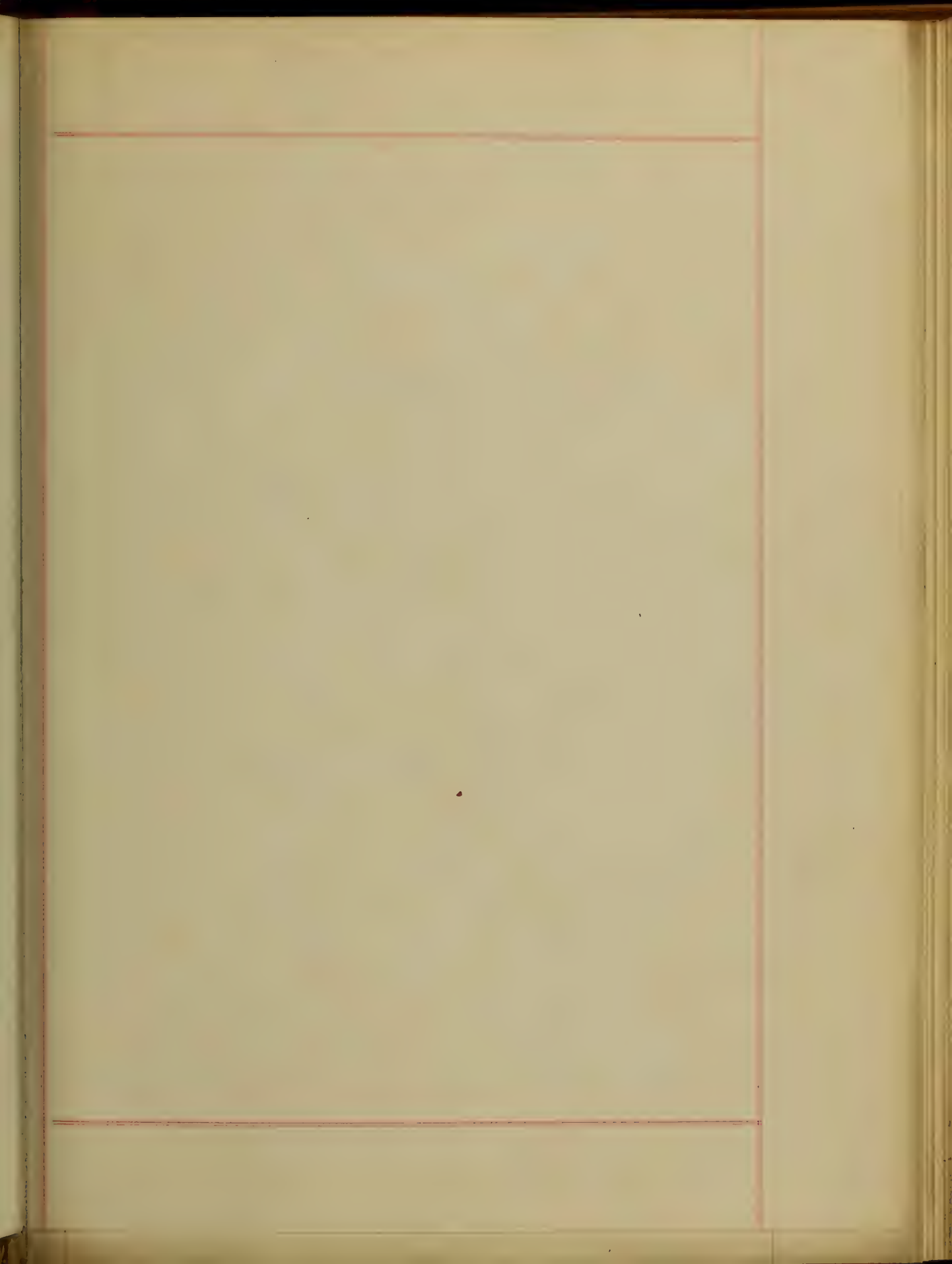
and each case in this instance will be found to owe its recovery of the following as recommended by G. Lewis Smith, M.D.

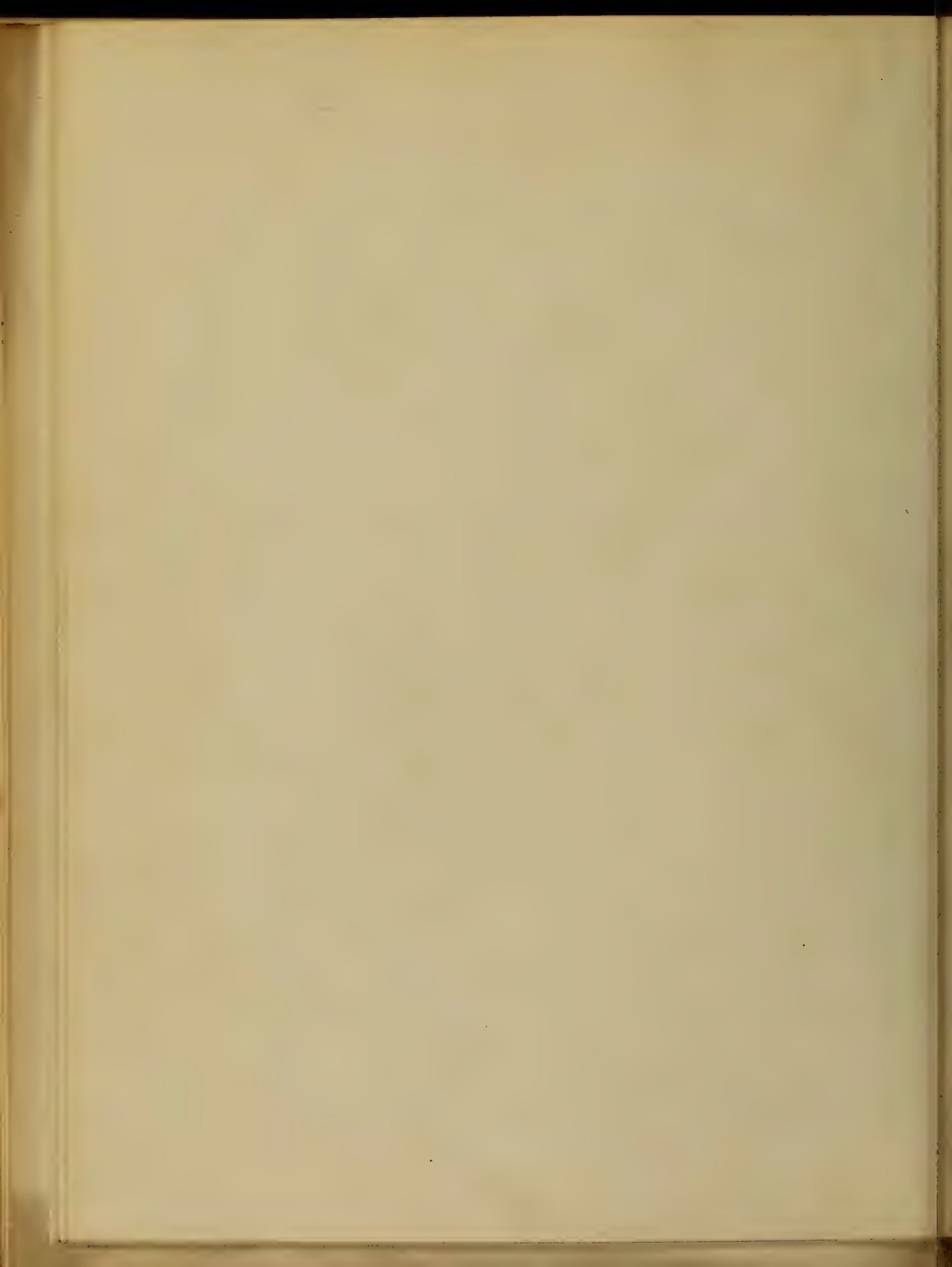
R Potas chlorat ʒj
Tine. ferri chlorid. - - - ʒj
Syr. simplic. - - - - ʒiv Mice

No drinks are allowed for a few minutes after its administration as well as after the use of the brush, so as not to wash it away too quickly from the gums.

The employment of tonics, especially of Quinia and iron, in the treatment of Lichthemia is almost universal in the profession. Our reliance must be upon these agents in those cases in which the system is infected from the first, more than upon topical remedies.







A
Dissertation
on
Dietis
by
H. M. Briel.

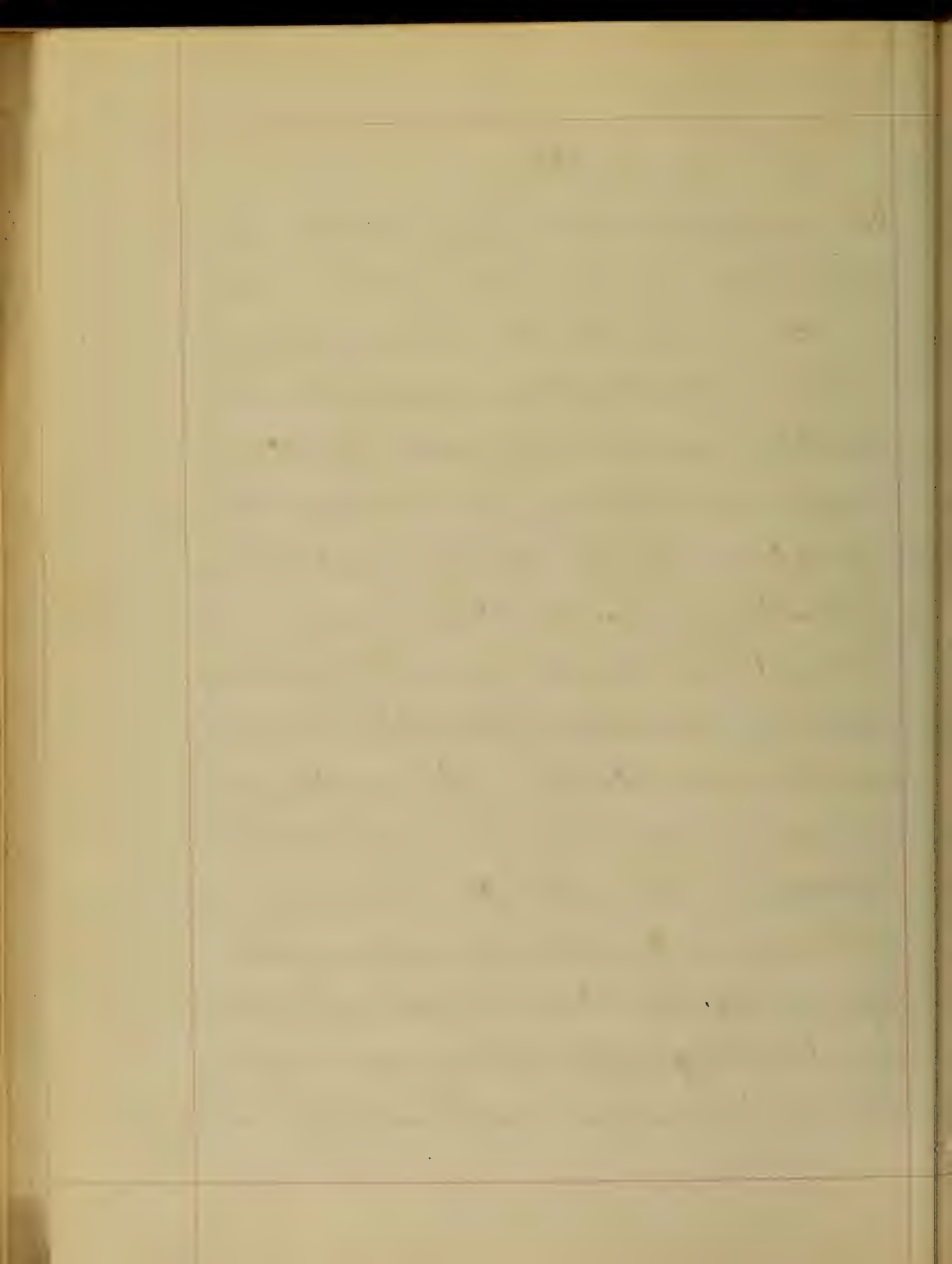
February 1877



Iritis.

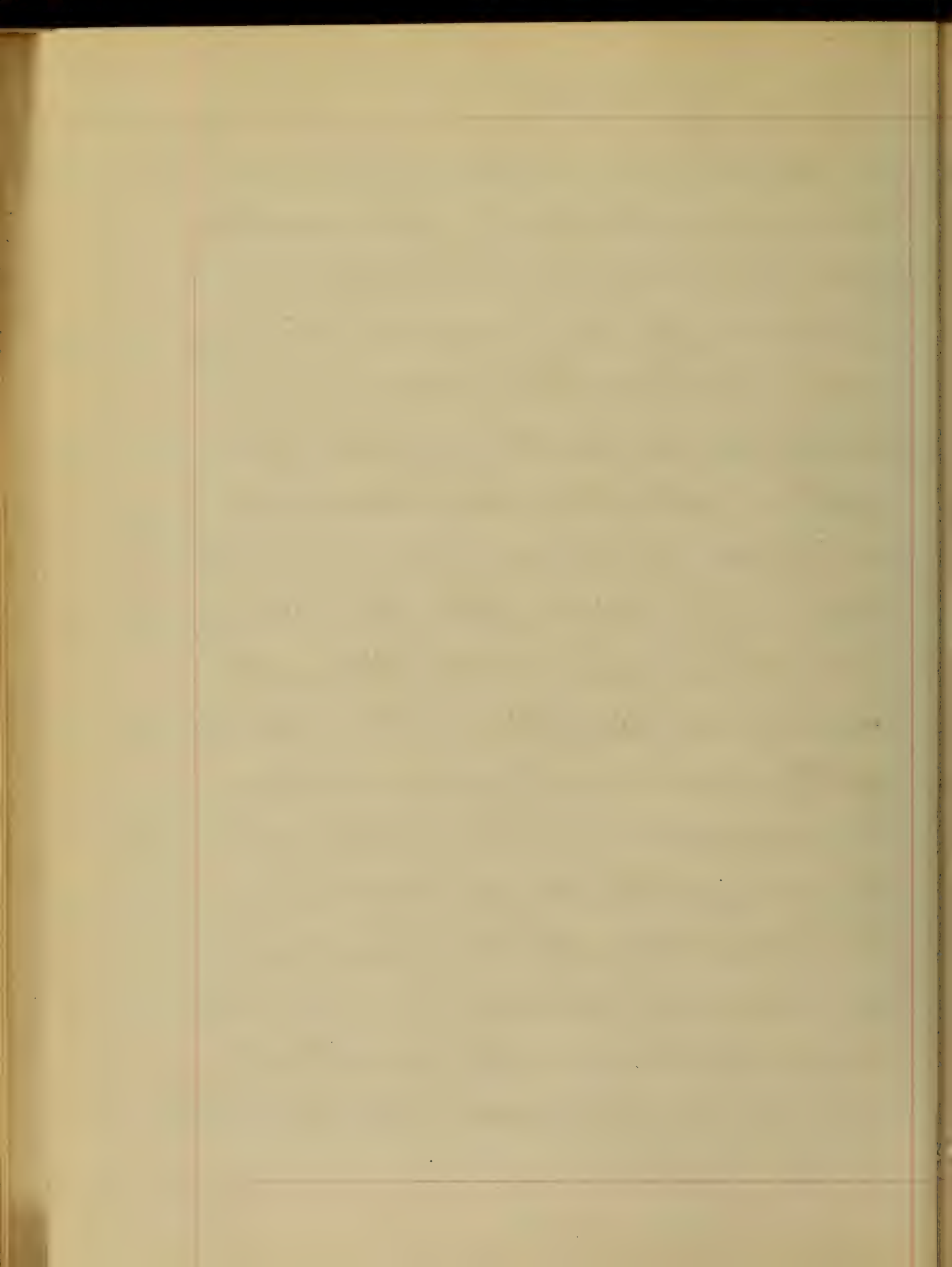
In considering this disease, a thorough knowledge of the parts involved is essential, in order that we may more fully understand its nature and the action of remedies addressed to its relief. Hence I shall, first, consider the anatomy of the iris and, afterwards, the disease in question.

The iris is a thin, circular and contractile curtain, almost similar to the choroid in general structure but containing more muscular fibres, perforated, not exactly in its centre, but nearer its nasal side, by a circular opening, the pupil, for the transmission of light into the eye. This opening varies according to the amount of light falling upon



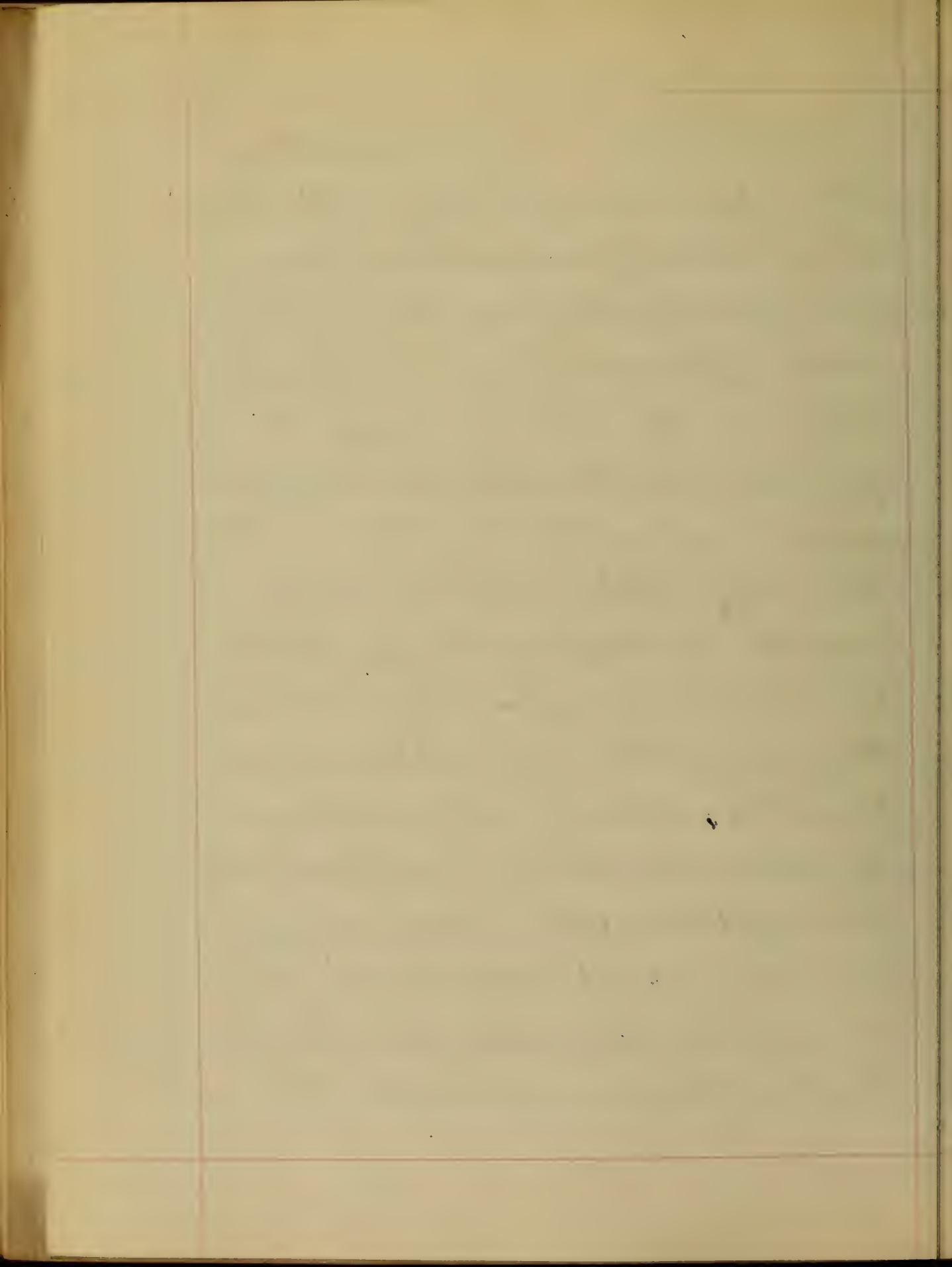
it, and in the changes of accommodation. The iris is connected by its circumference with the choroid, and is continuous, posteriorly, by its marginal attachment with the anterior border of the ciliary processes, anteriorly, by the ligamentum pectinatum with Descemet's membrane. It hangs nearly vertically behind the cornea with its pupillary border, when not dilated, resting upon and in front of the anterior capsule of the lens.

The muscular fibres, which enter into its composition, are arranged in two ways, some around the pupil, forming a sphincter, and known as the circular fibres, others radiating from the pupil towards the periphery, forming a dilator of the



opening, and known as the radiating fibres. Its vascular supply is obtained from the long and anterior ciliary vessels, and also from those of the ciliary processes. These vessels are arranged in two circles, one near the pupillary, the other near the ciliary margin.

It is supplied by the third pair of cranial nerves, and the sympathetic. The third pair supplies the pupillary ^{origin}, the sympathetic the radiating fibres. The anterior surface of the iris is covered by pavement epithelium, continuous with that of Descemet's membrane, the posterior, with a few exceptions, by a dense layer of pigment cells, which prevents the light from passing through.

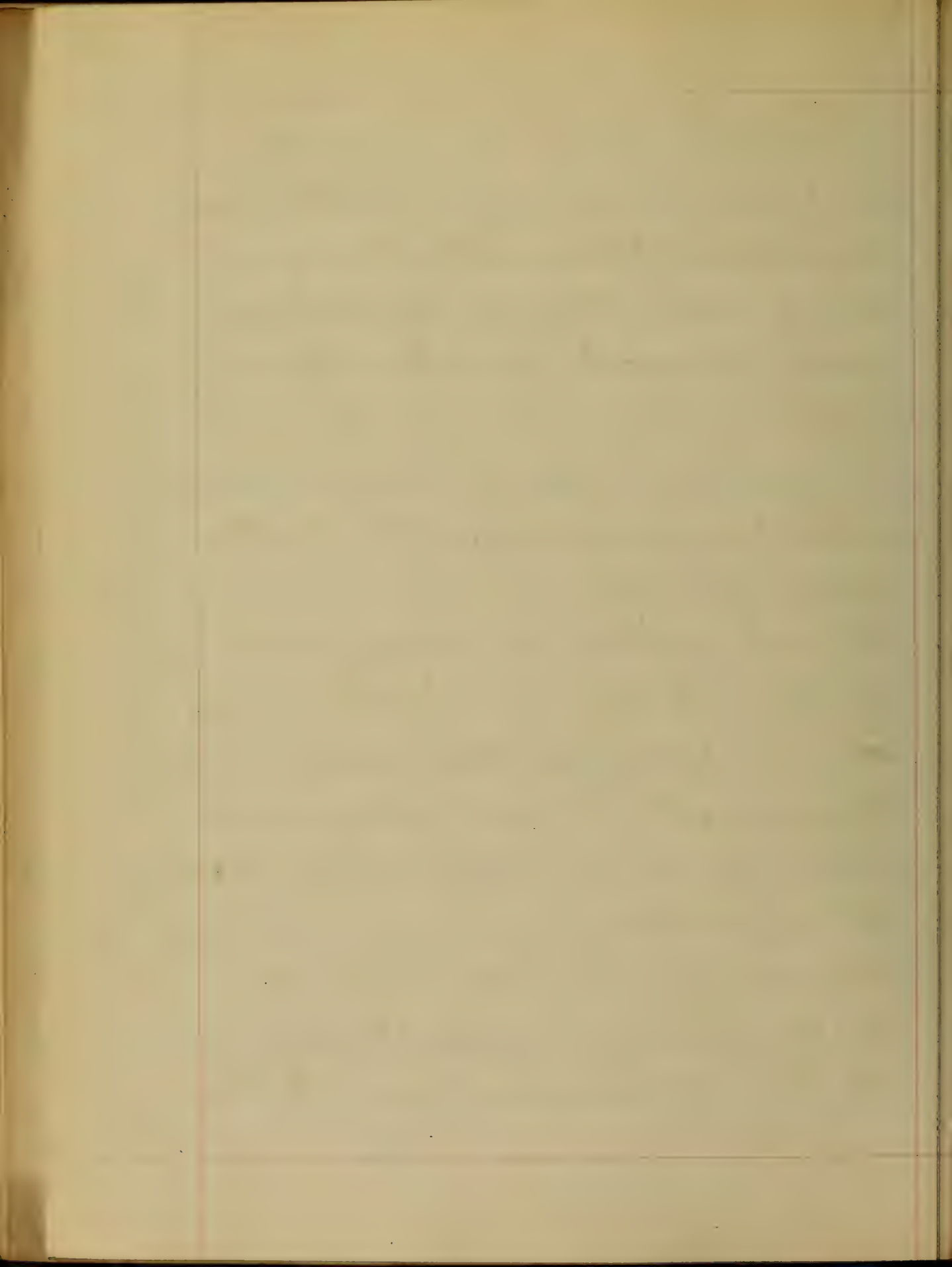


The iris, when healthy, presents a bright, glistening and glossy surface with sharply defined fibrillae, ^a and circular pupil readily contracting and expanding under the slightest variations of light.

Iritis, inflammation of the iris, is seen under two principal forms, the plastic and the serous.

In plastic iritis, there is an exudation of lymph both in the structure of the iris and around the margins of the pupil, which tends to produce adhesions of the iris to the anterior capsule of the lens.

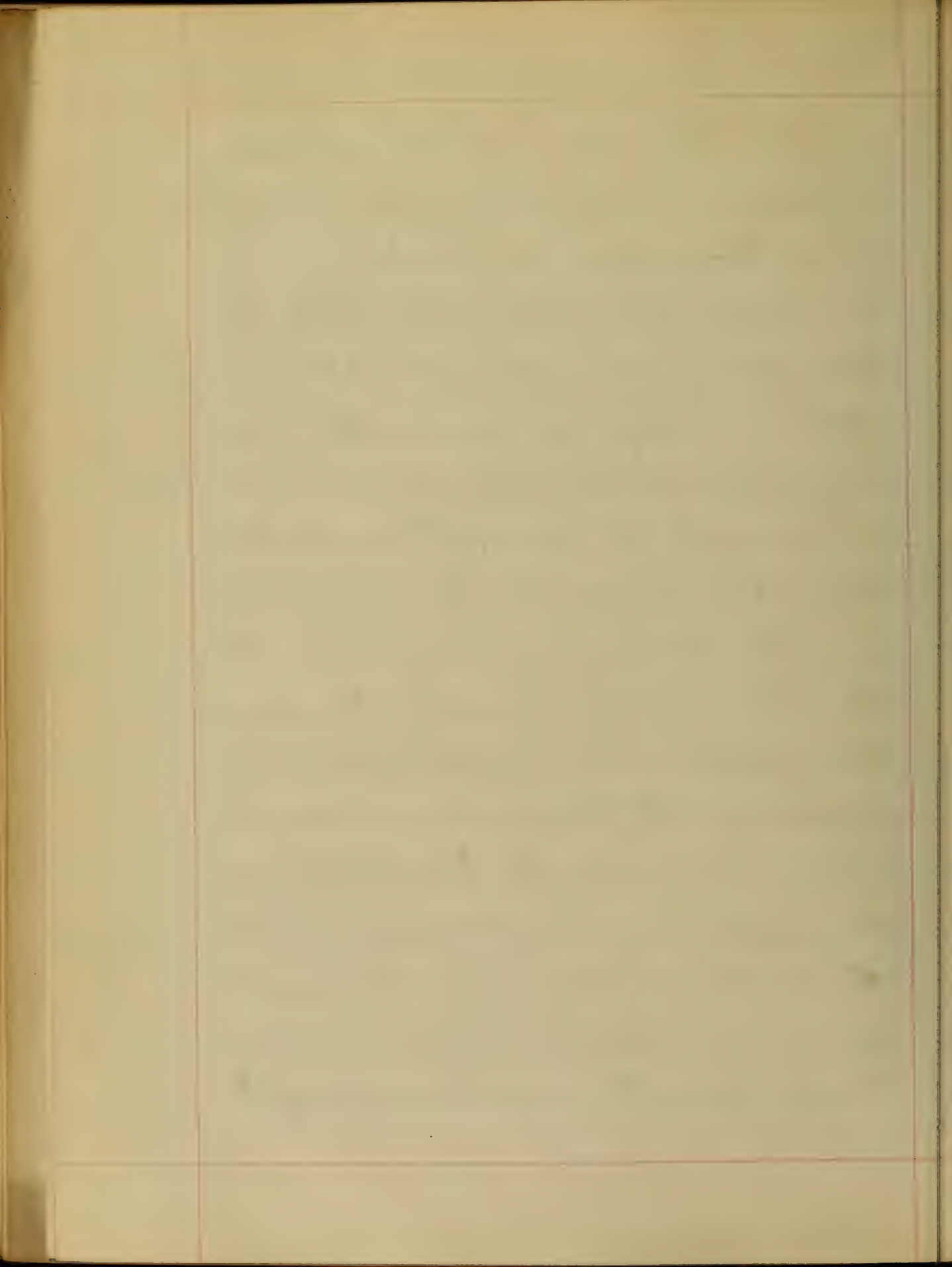
In serous iritis, there is an effusion of turbid liquid, having no tendency to form adhesions of the iris to the



lens, but, ^{what} accumulates in the eyeball, causing
increase tension and obstruction of
the intra-ocular circulation

In iritis, the iris loses its bright, glistening
and glassy appearance, and becomes
dull and hazy. In every case, the pupil
is more or less interfered with. In
the majority of cases, it is contracted,
either from the swelling of the iris, or
from the adhesion binding the iris to
the lens. If adhesions have been formed,
the pupil, ^{if it dilates at all,} will not dilate ^{regularly} under the in-
fluence of atropia. In some cases in
which the disease has been maltrated,
the pupil is universally adherent to
the anterior capsule of the lens, and
wholly immovable.

Vision may be impaired, owing to



the turbidity of the aqueous humor
and extent to which the pupil is in-
volved by the exudation.

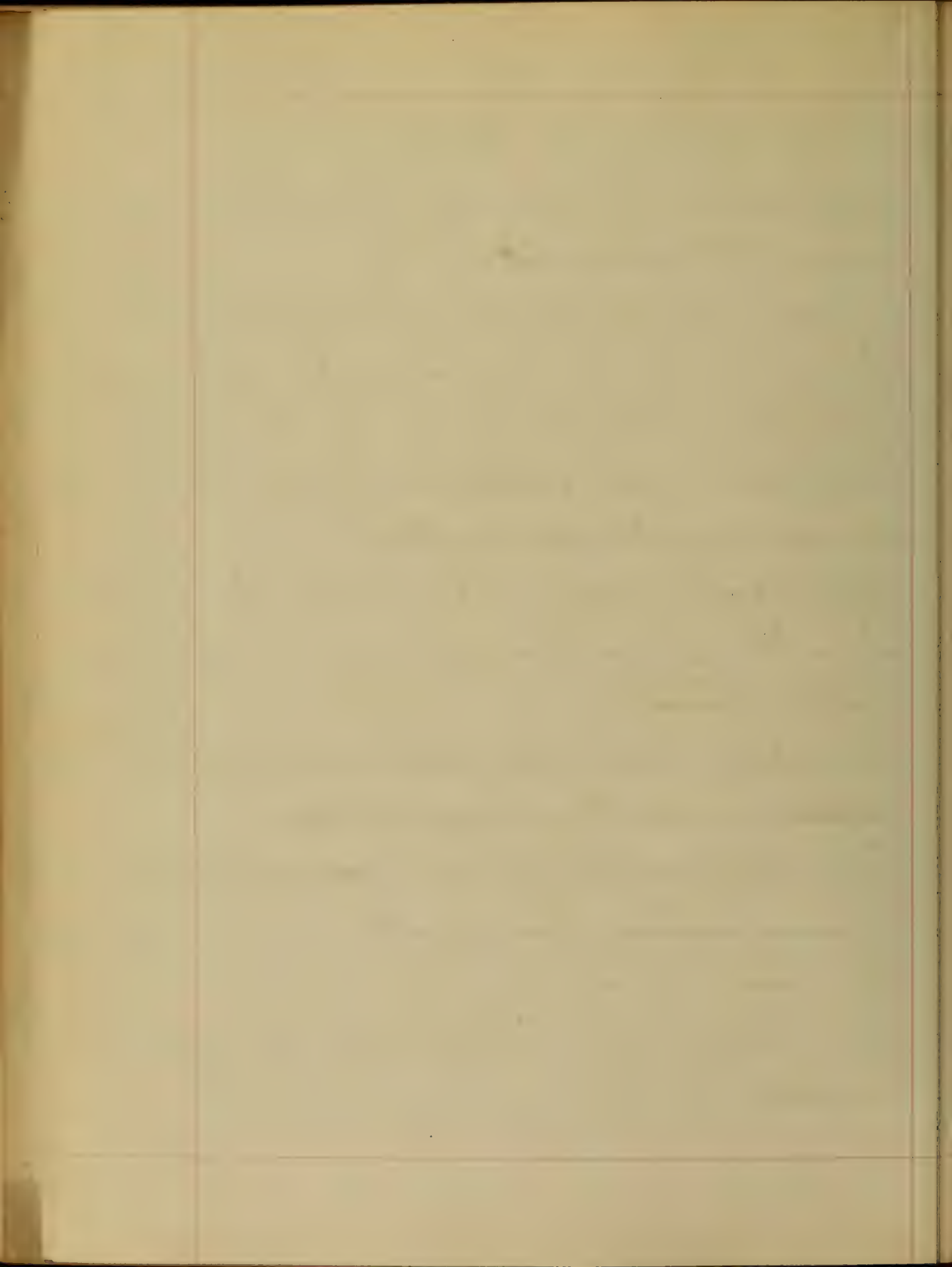
In very many cases, there is no pain,
but in a few it may exist, extending
over the corresponding side of the
head and face, and may become
so severe as to require treatment.

The eyeball should not be sensitive to
the touch. Should pain exist upon pressure,
cyclitis coexists.

Photophobia and lachrymation sometimes
exist, but not to a marked degree.

The sub-conjunctival tissue is injected,
forming a pink zone around the
cornea.

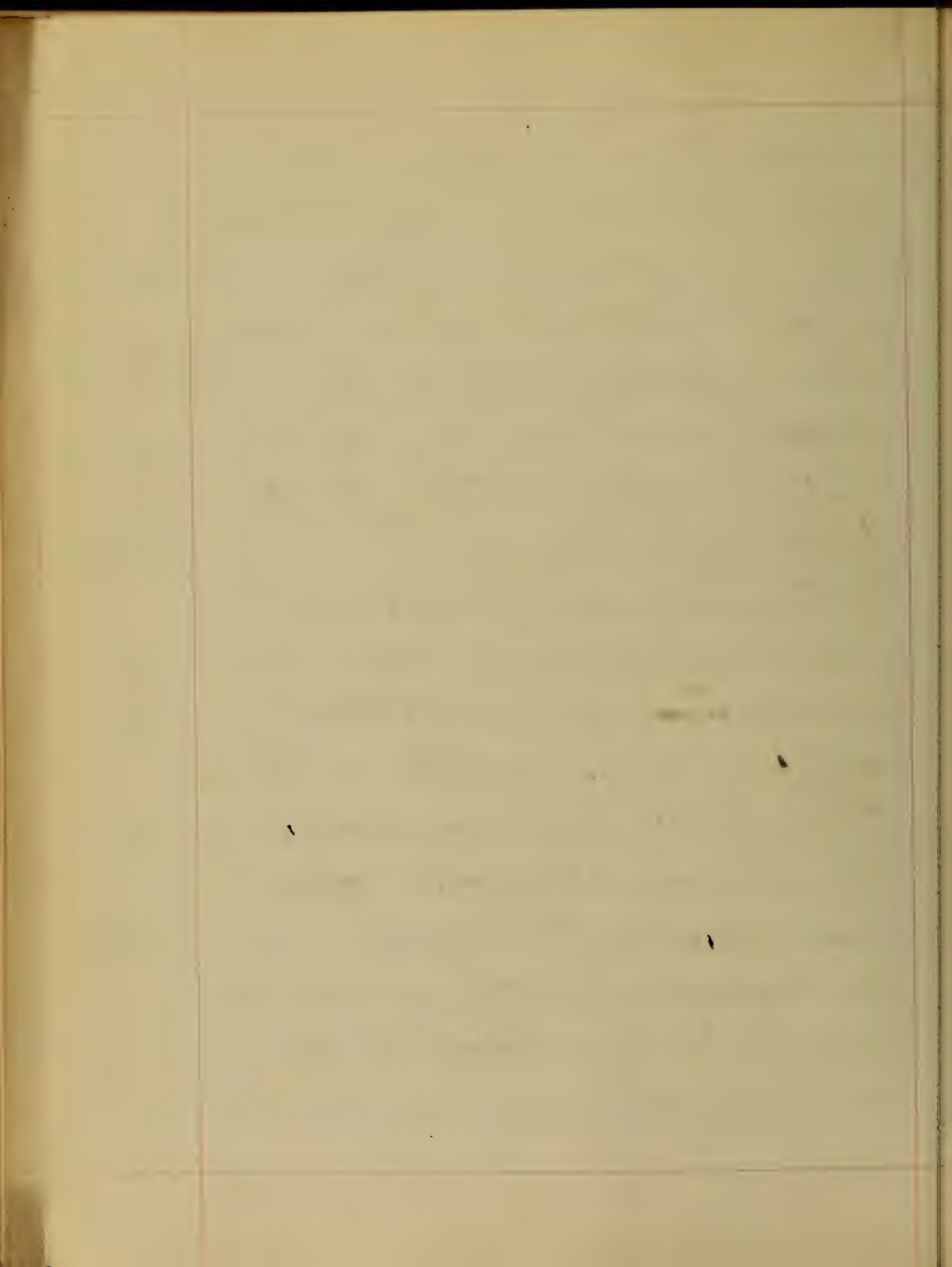
In serousritis, besides the symptoms
already mentioned, there is increased



tension, partial dilatation of the pupil and cloudiness of the cornea from the action of the effused fluid upon its epithelium. In some cases, the iris is pushed back, and the cornea bulged forward on account of the distention of the anterior chamber by the effused fluid.

Iritis may arise from various causes; its common causes are injury, ~~and~~ ^{or} some constitutional affections, such as syphilis, or rheumatism. When caused by syphilis, it occurs during the secondary stage and affects most frequently both eyes.

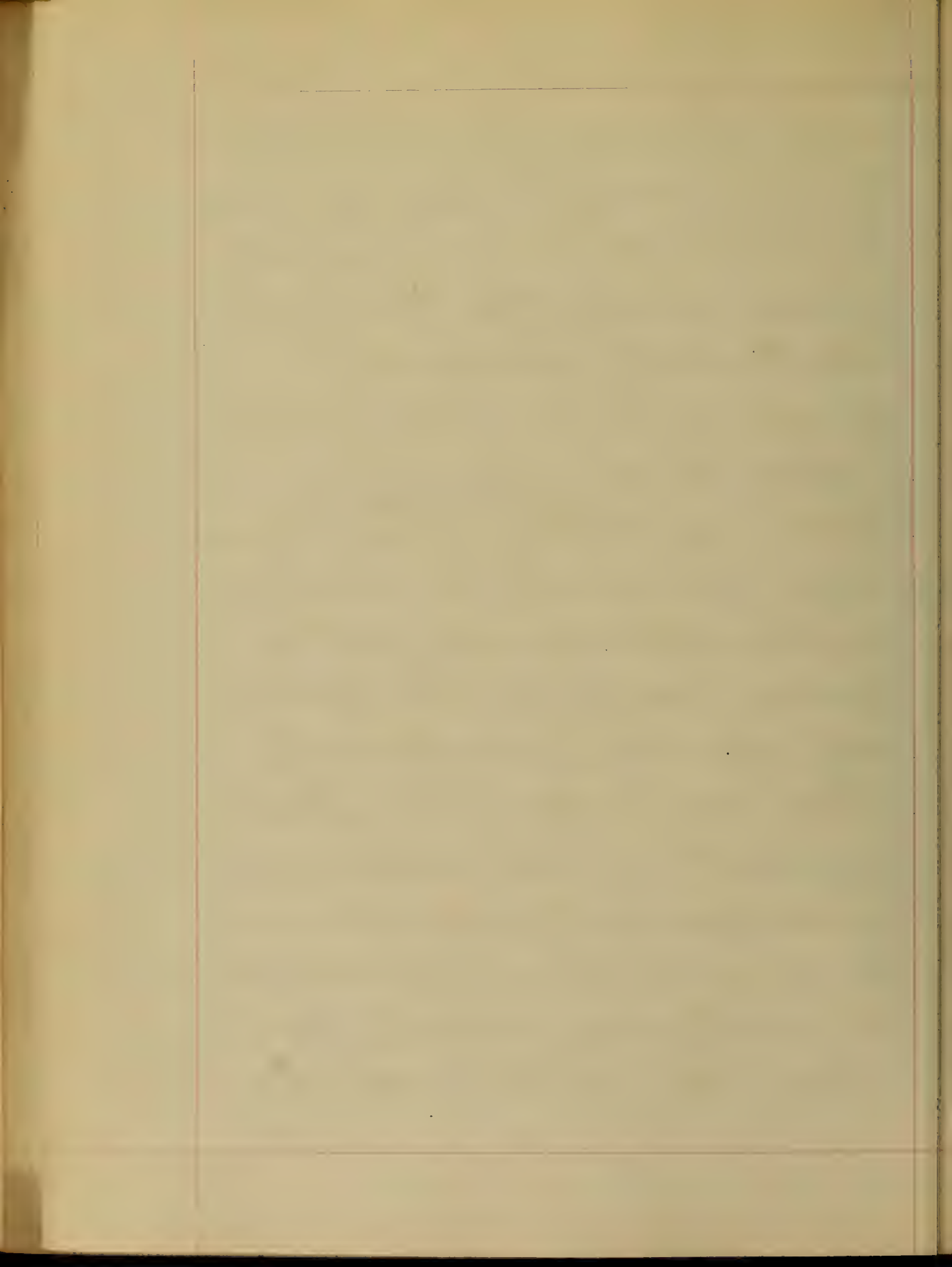
The diagnosis of iritis is generally very easy. The loss of color, ^{the} dull, hazy appearance of the iris, the pink zone around the



cornea, the contracted pupil with
impaired mobility, the feeling of discom-
fort in the eye and no pain upon
pressure, are symptoms by which it
can be readily recognized.

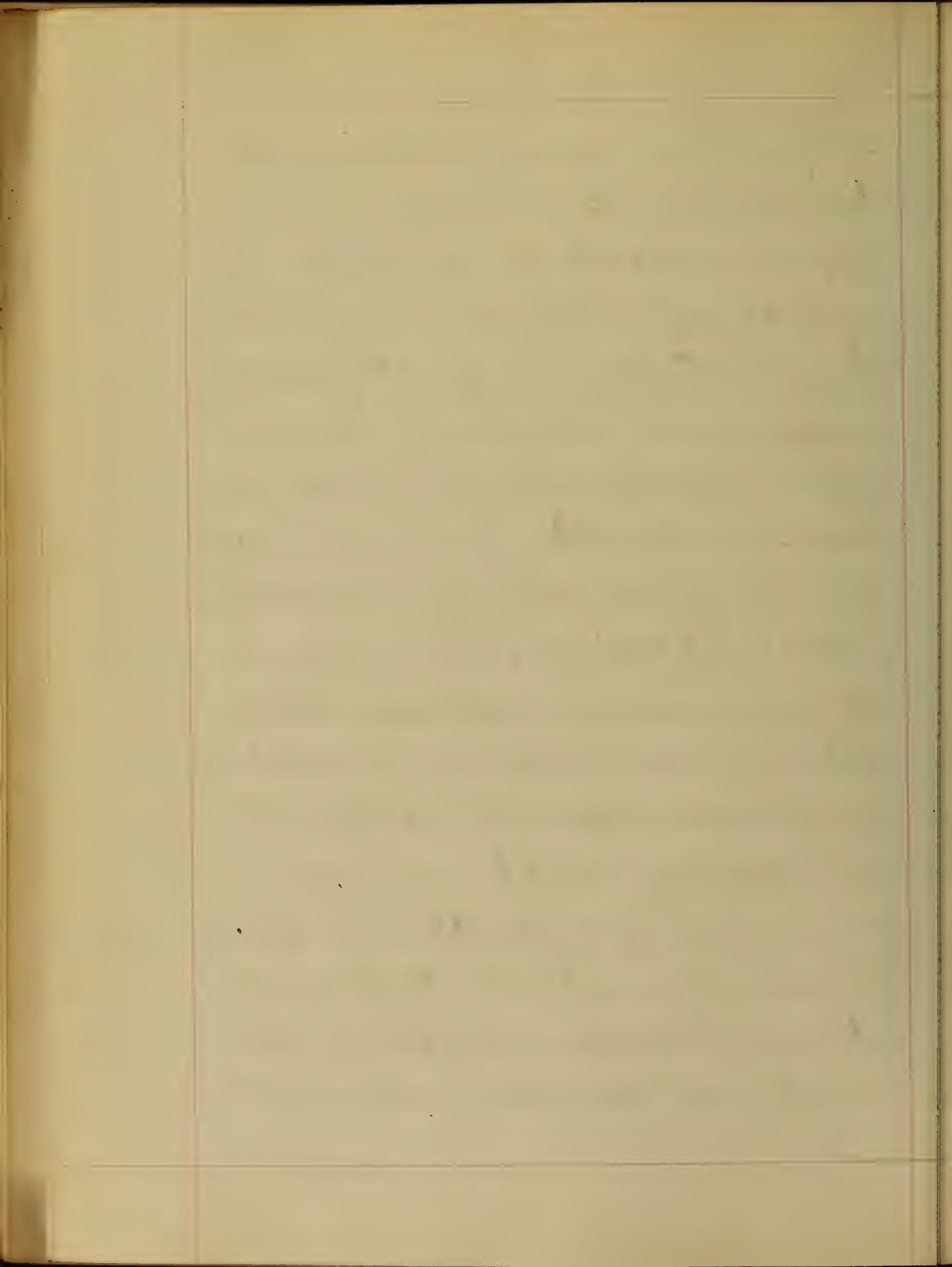
If any adhesions exist, they can be
readily discovered by using a so-
lution of atropia. The ^{degree of} mobility
of the pupil can be discovered by
closing the well eye and alternately
shading and exposing the affected
one. If healthy, it will be seen to
dilate and contract readily, but, if
its mobility is impaired, it will dilate
irregularly, if it dilates at all.

The prognosis depends very much upon
the severity and cause of the in-
flammation. If the disease be



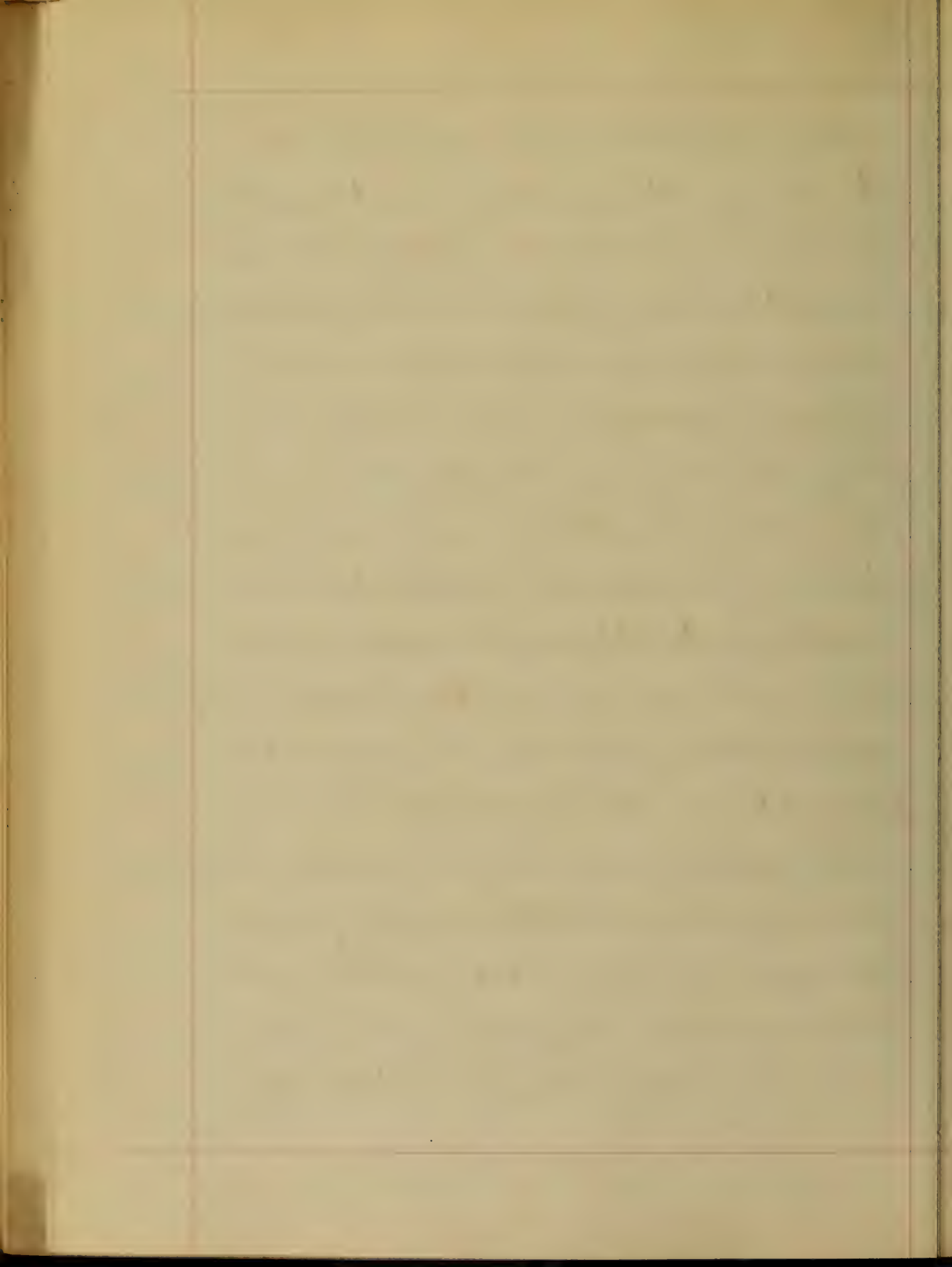
seen early, or if any adhesions have
been formed between the edge of the
pupil and anterior capsule of the
lens, or whilst they are so slight as
to yield to the use of atropia, the
prognosis is more more favorable
than if numerous firm bands of
adhesion have been formed, which re-
sist the most energetic use of atropia.
In traumatic iritis, the prognosis is
generally unfavorable, because other
structures are involved in the in-
flammation, and the extent of their
implication must be considered.

In every case of plastic iritis of only
moderate severity, the tendency is
towards recovery, and, whenever this
is the case, we should attempt to

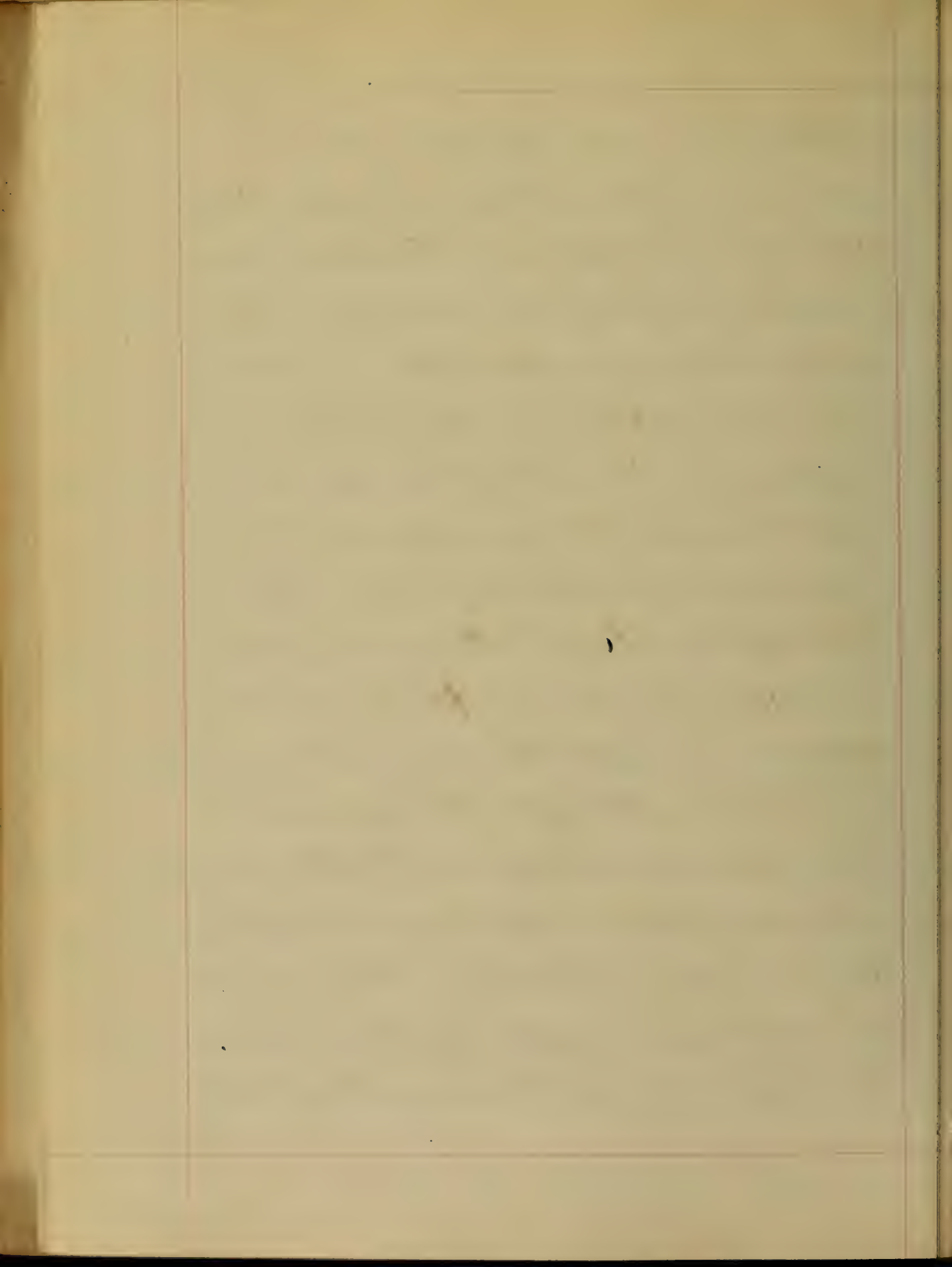


favour it, and prevent adhesions, or
to overcome them, if any have been formed.
The eyes should be used as little as
possible, and protected from irritants.
No astringent solutions should be
used, for, acting as direct irritants,
they increase instead of diminishing
the inflammation.

The point of greatest importance in
iritis is to obtain full dilatation of
the pupil as soon as possible, and for
the attainment of this a solution
of atropia should be applied to
the affected eye. The atropia, by pro-
ducing full dilatation of the pupil,
removes the iris from contact with
the anterior capsule of the lens,
thus preventing the formation of

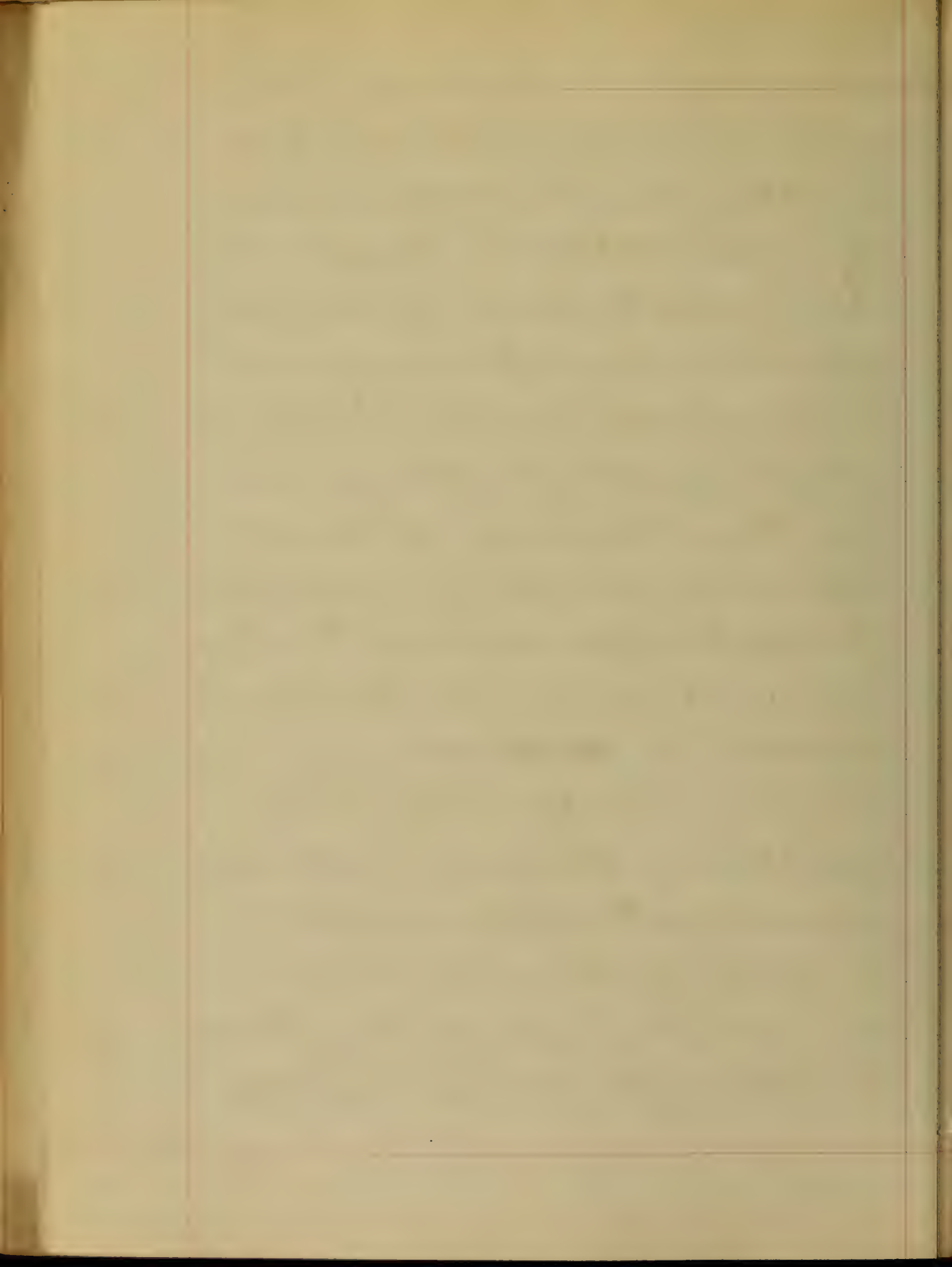


adhesions, and establishes a free communication between the Chambers, thereby diminishing the tension and relieving the intra-ocular circulation. Rest, which is so essential in all inflammations, is afforded to the inflamed tissues by this complete dilatation; for by paralyzing the circular fibres their constant efforts to respond to the stimulus of light is restrained and perfect rest is assured. The solution should be of sufficient strength to overcome the resistance offered by the inflamed tissues and exude lymph. A solution containing atropia gr. iij to water ℥j is sufficiently strong. Four or five drops of this should be placed



upon the cornea five or six times
per day. When the adhesions consist
of narrow bands, they may be broken
by the constant use of atropia,
the pupil again becoming circular
and capable of responding to the in-
fluences of light. The atropia should
not be withdrawn immediately after
full dilatation has been produced,
but continued (a weaker solution being
used) until all evidences of inflam-
mation have disappeared.

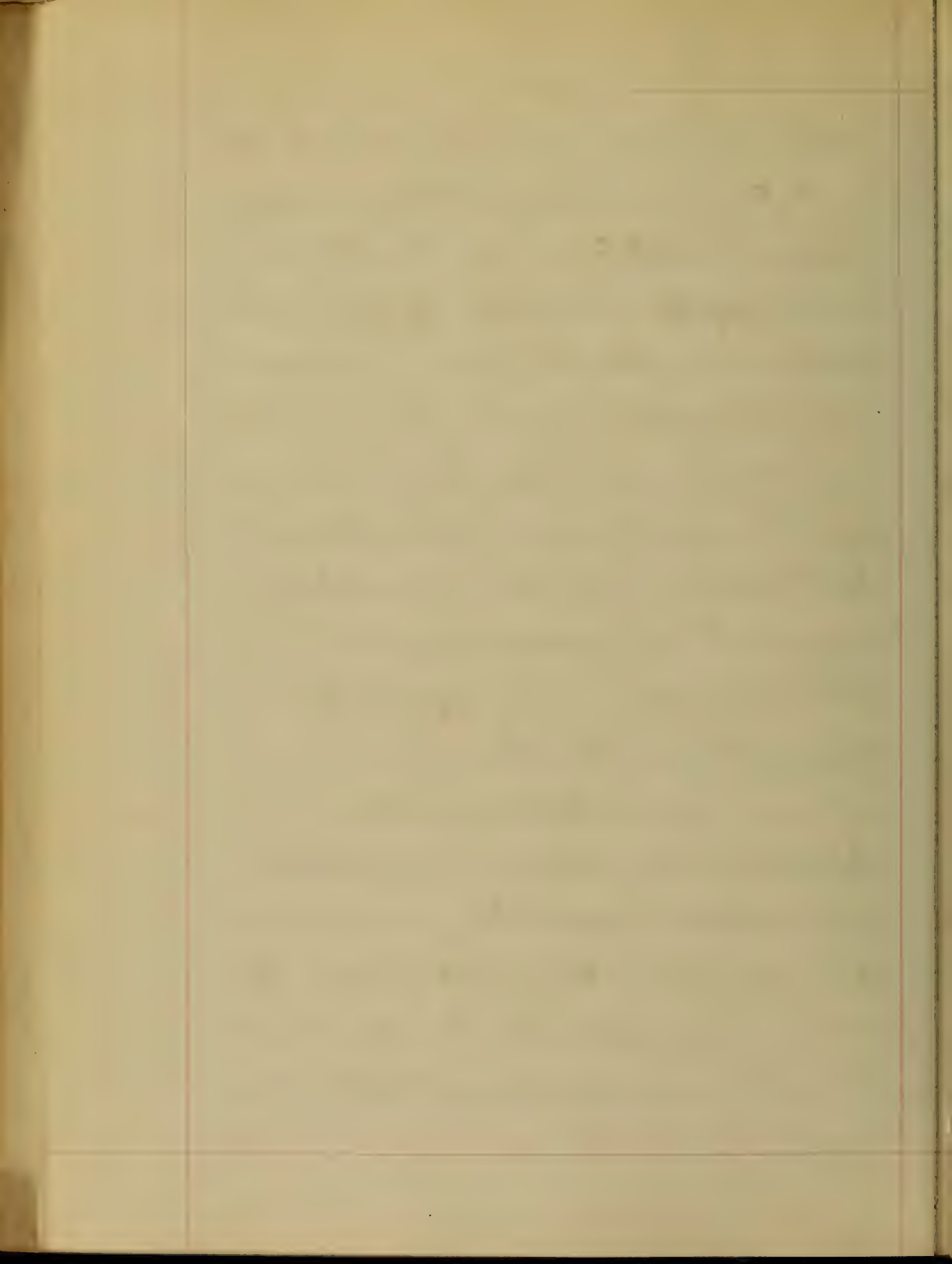
Sometimes the action of a strong
solution of atropia is resisted, and
increases rather than diminishes the
irritability of the eye. In such cases,
the application of leeches to the temple,
or tapping the cornea, very promptly



alleviates pain, and, by relieving the
irritation and congestion, produces
freer absorption of the atropia
and rapid dilatation of the pupil.
In serous iritis, the pupil may become
fully dilated under the influence
of atropia without any abatement
in the severity of the symptoms; the
obstructed circulation presenting a
barrier to the progress of repair.

The remedy here is paracentesis of
the anterior chamber by which the
fluid is evacuated, diminishing the
tension and relieving the circulation.

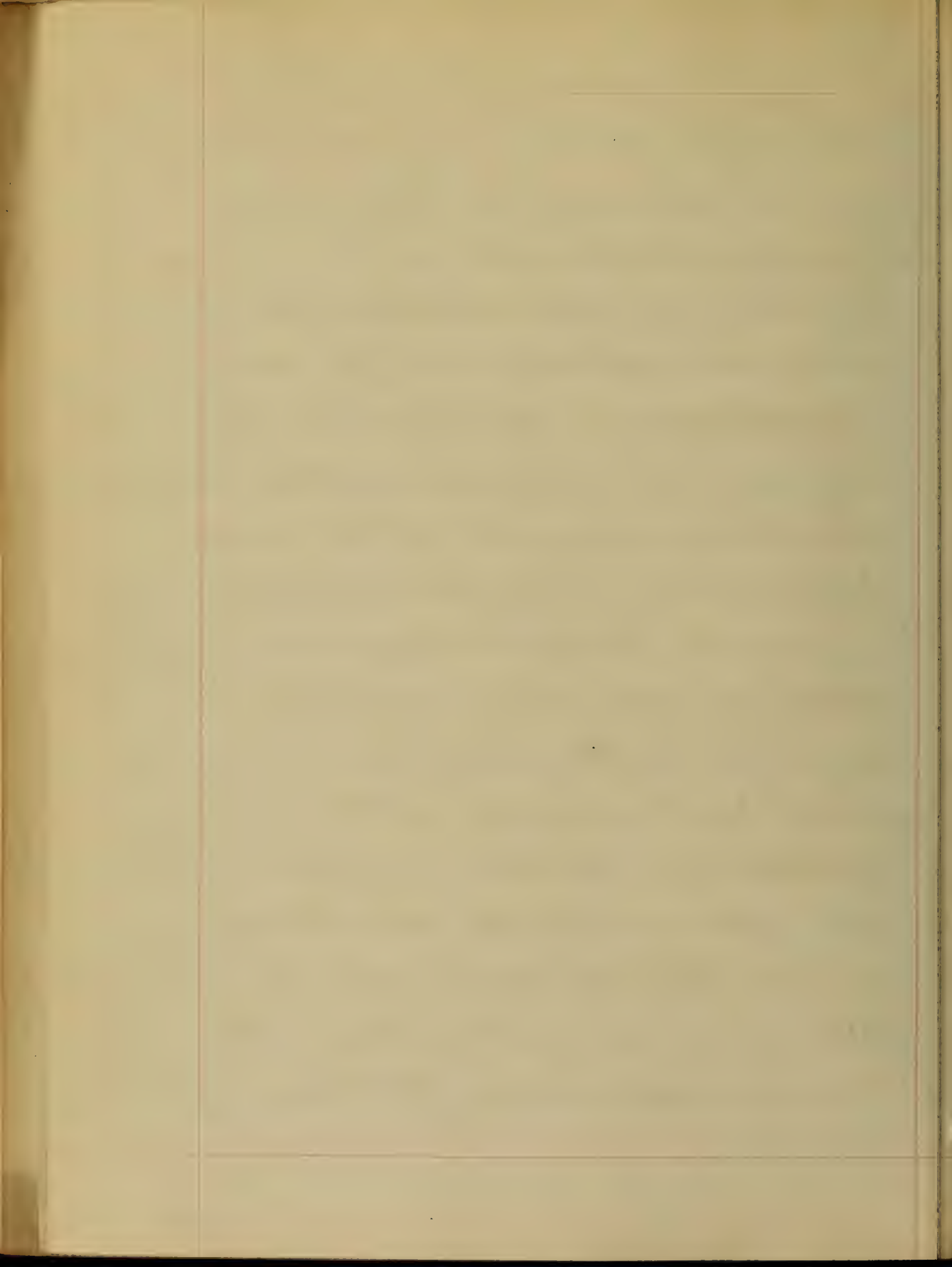
Paracentesis can be performed with
any sharp-pointed instrument by
those accustomed to eye operations,
but, in unskillful hand, the stop



paracentesis needle is best, as it cannot enter far enough to injure the iris, or lens.

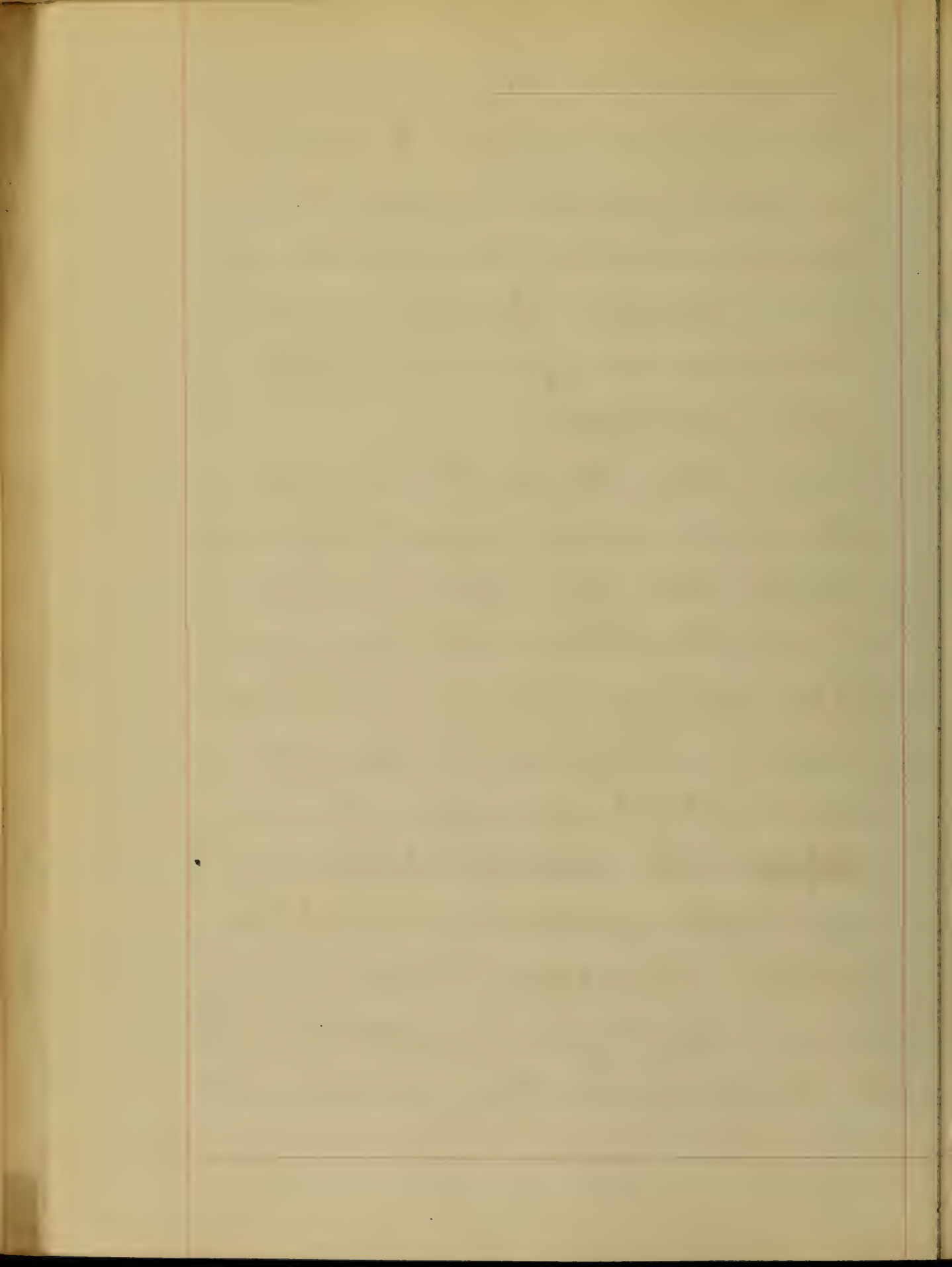
This form of *iritis*^{is} commonly connected with some disturbance of the general health, such as that produced by syphilis, or by imperfect action of the kidneys, and our object should be to improve the general condition, if possible, by internal remedies, while we apply atropia locally to the eye. The condition of the intra-ocular tension, and of sight, should be carefully noticed.

In *iritis*, occurring as an evidence of constitutional syphilis, mercury should be given internally along with the local application of atropia.



In some cases not due to syphilis,
in which adhesions have been
formed, mercury exercises a most
beneficial effect, by softening the
adhesions and producing their
ready absorption.

The patient should be put under
the influence of mercury as soon
as possible. One grain of calomel
in combination with one-fourth
of a grain of opium may be given
every three or four hours, until
its constitutional effects become
apparent. Llorosive's sublimate
one-twelfth of a grain three times
a day is very good. Mercurial oint-
ment may be rubbed ^{inwardly} into the thighs
or arms once or twice a day, until

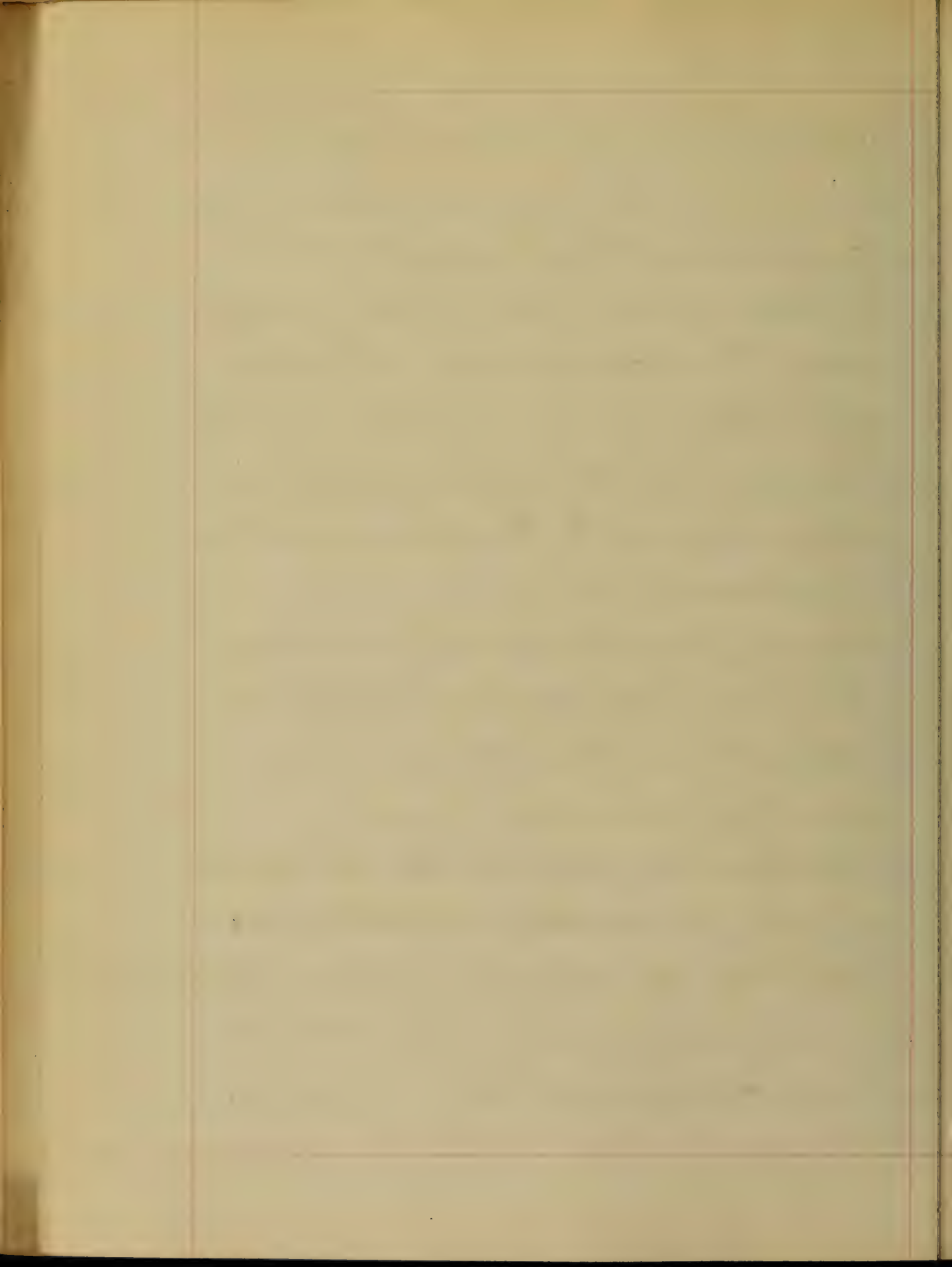


The mouth becomes slightly affected.
Not more than a half-drachm should
be used at ^{each} ~~one~~ application.

In those cases in which the mercury
fails to do good, or in which it
would be deleterious, iodide of potas-
sium should be used in doses
of from five to ten grains ^{ter die} increased
if necessary.

In all cases the atropia should
be used regularly, and ^{in solutions} of proper
strength, while internal remedies
are being given.

If the iritis resists all the remedies,
and if broad bands of adhesions
have been formed and the sight
much impaired, an iridectomy should
be at once performed.



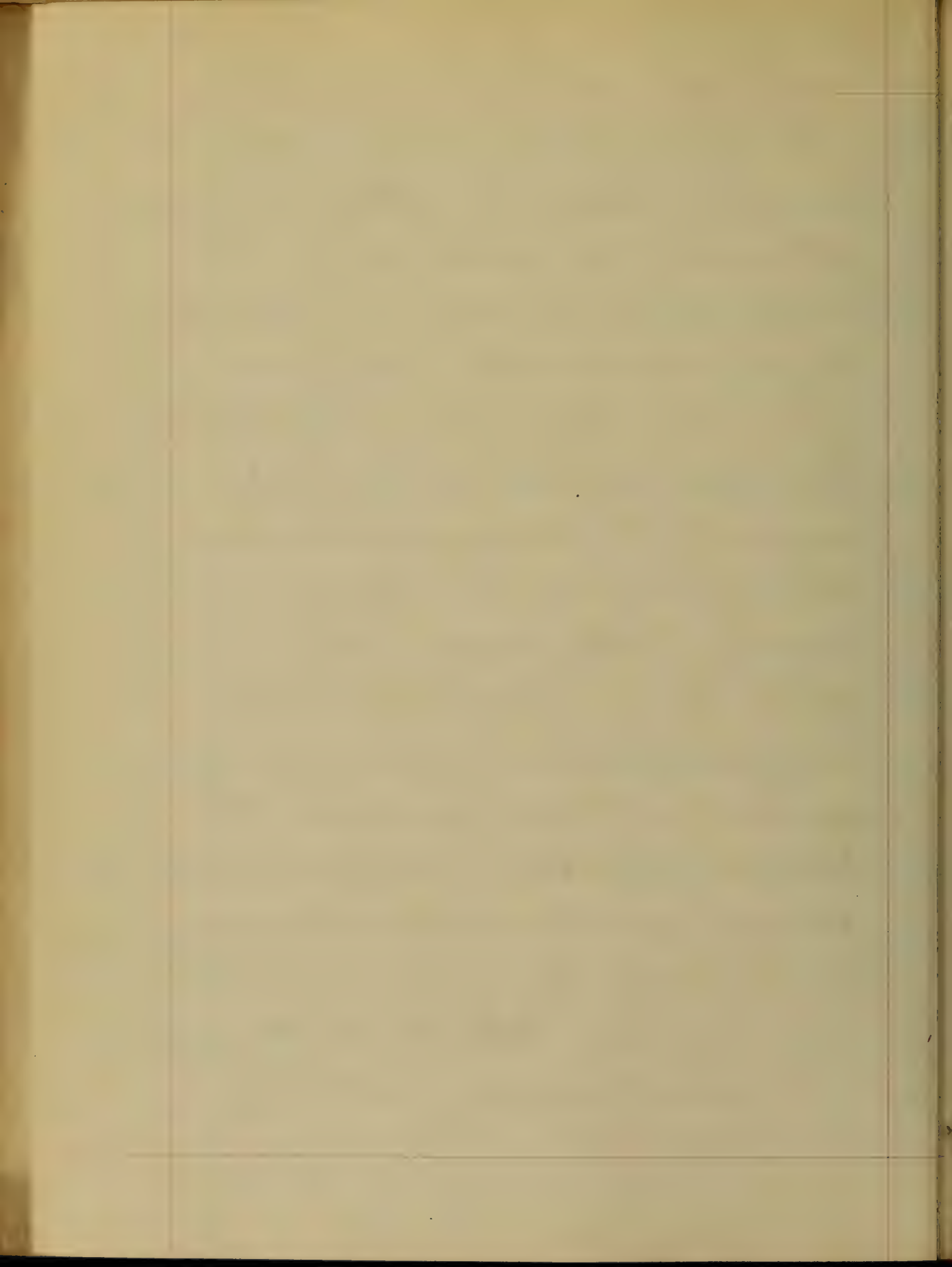
The operation of iridectomy consists in tearing the iris. In iritis, as small a piece as possible should be removed, and ^{it} should be taken ^{from} directly upwards, for in this direction the upper lid will not only hide the deformity, but will also prevent the retina from being irritated by too much light.

The instruments used in performing an iridectomy are; - "a wire speculum for keeping the lid separated, a pair of fixing forceps for steadying the eyeball, a long, narrow, or lancet-shaped knife for cutting into the anterior chamber, a pair of iris forceps slightly bent for catching the iris and drawing it out through the incision and,

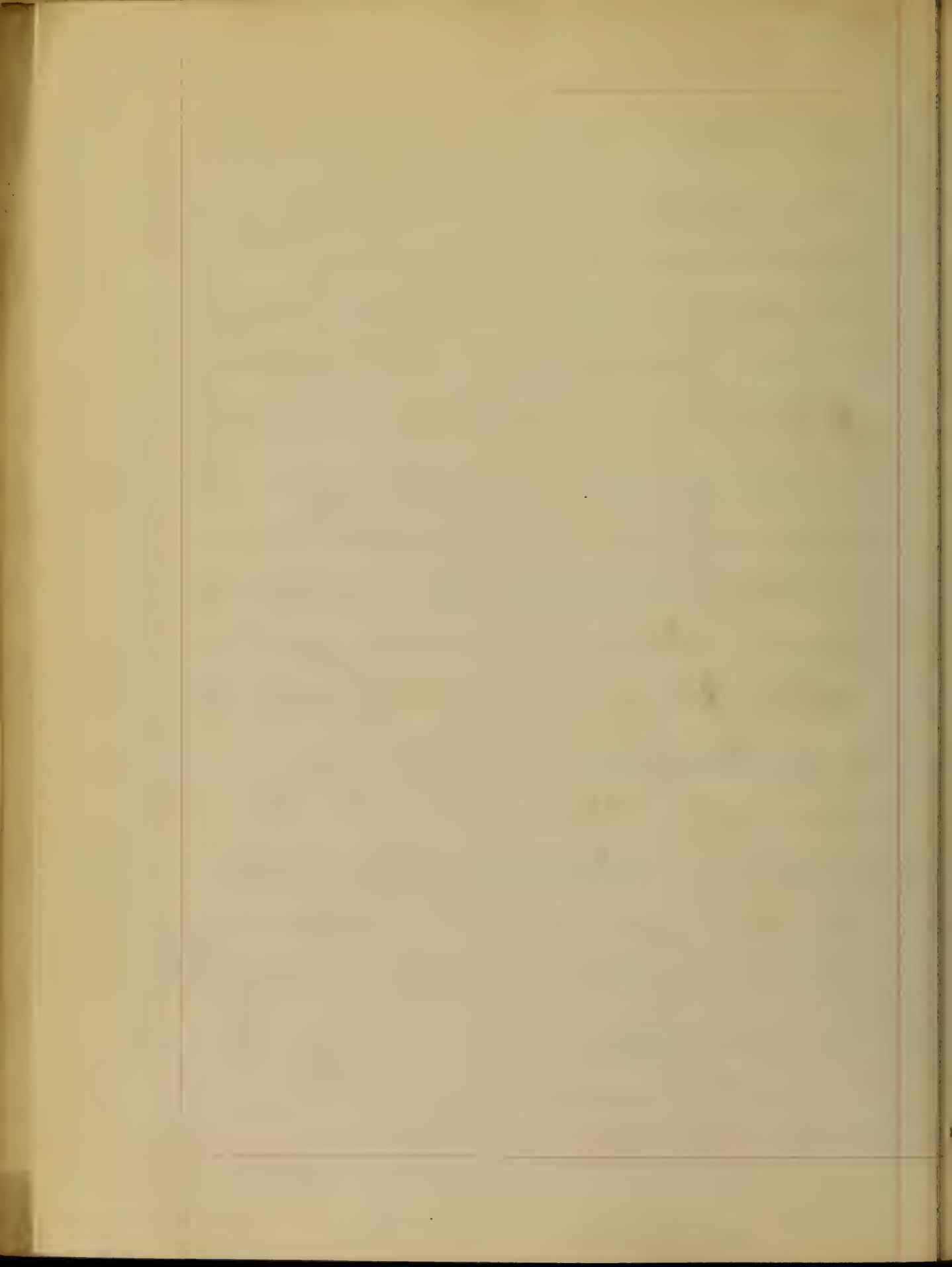


lastly, a pair of iris scissors slightly bent at an angle for cutting the iris after it has been drawn out.

Iridectomy is thus performed: "The patient being in the recumbent position, and under the influence of chloroform, the surgeon separates the lids by means of the wire speculum, and, standing behind the patient's head, fixes the eye by seizing with the fixing forceps the conjunctiva and subjacent fascia, at a point directly opposite to that of the proposed section. A lance-shaped iridectomy knife - straight for the outward, but angular for the upward or inward section - is then to be thrust through the sclerotic at about half a line

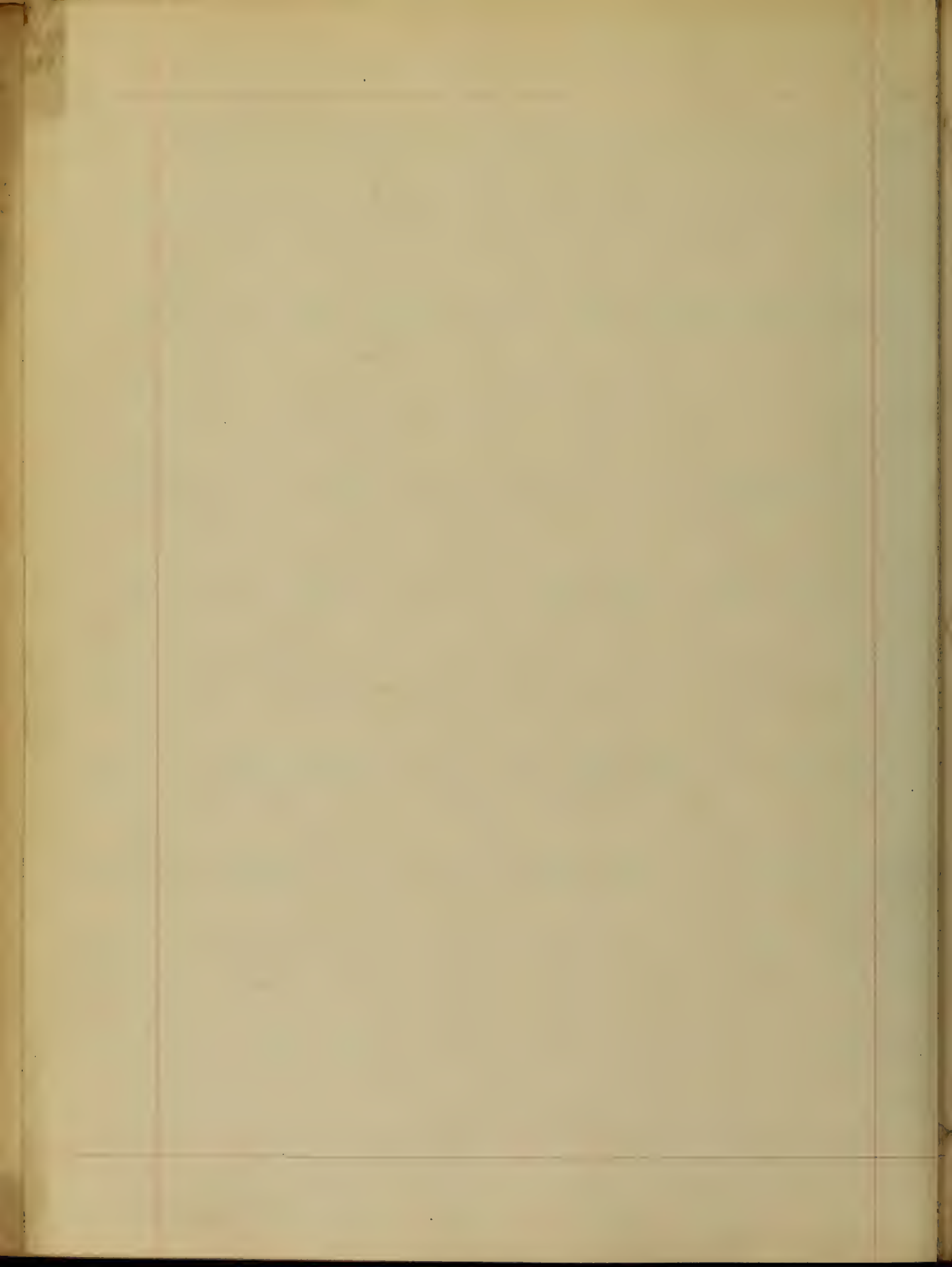


to a line from its junction with
the cornea, the handle being well
depressed, so as not to wound the
iris or lens, while the blade slowly
thrust onwards, until the section
is ^{at} the desired extent. The knife
is then slowly withdrawn, so as to
allow the slow escape of the aqueous
humor. The fixation forceps are now
handed to an assistant, who may
rotate the globe a little downwards,
and steady it while the surgeon
excises a portion of the iris; this is
done by introducing ^{the} curved iris
forceps, expanding the blades so
as to grasp the pupillary margin,
cautiously withdrawing the forceps
with the included portion of



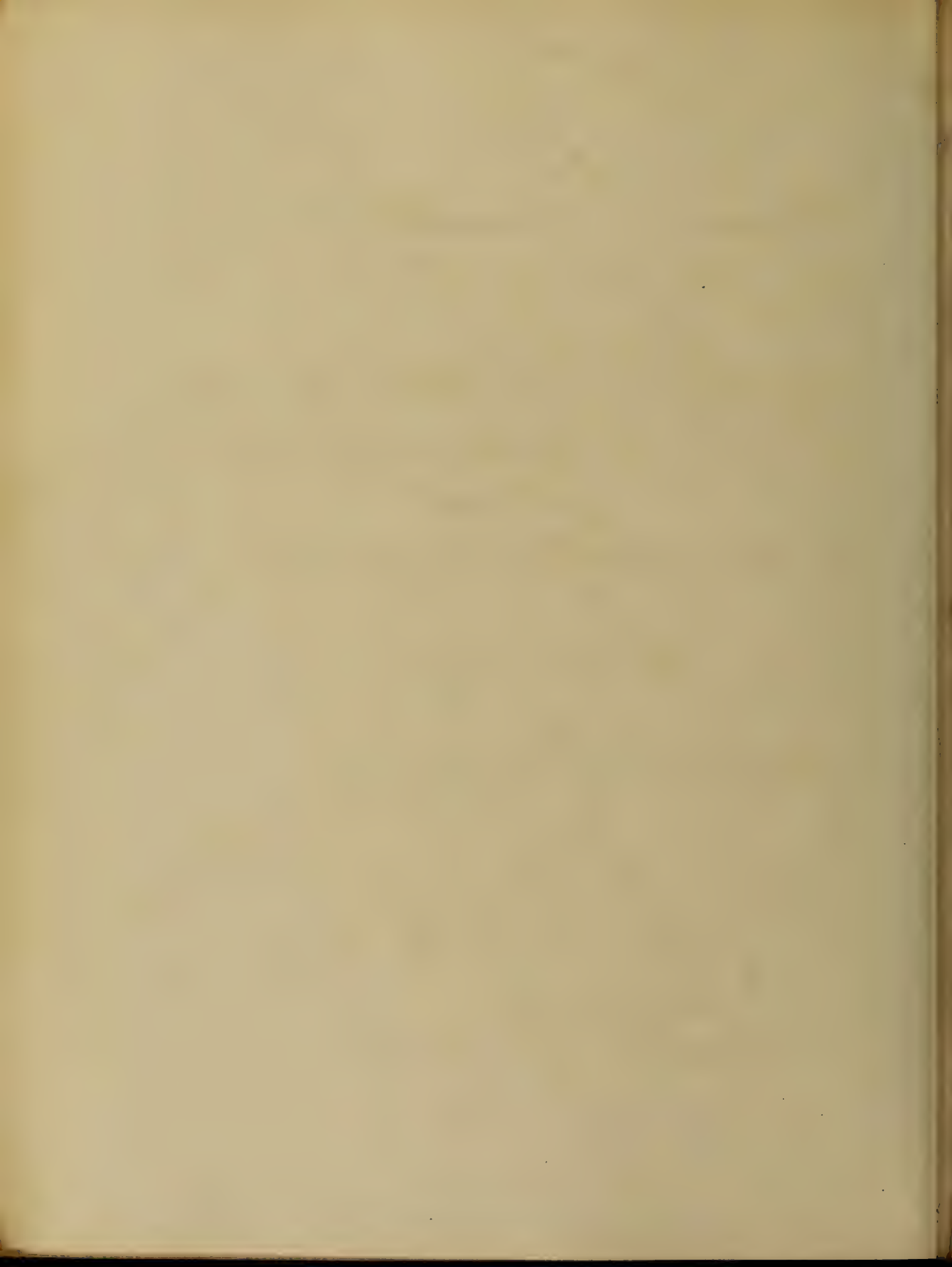
iris, and snipping off the latter close to the wound by one or two cuts with the curved iris scissors.

If the section of the iris cause hemorrhage into the anterior chamber, the escape of blood may be facilitated by carefully introducing a curette, and making cautious pressure with the fixation forceps. The speculum being removed, the lids are gently closed, and a compressing bandage applied. For the first few days, both eyes should be excluded from the light."



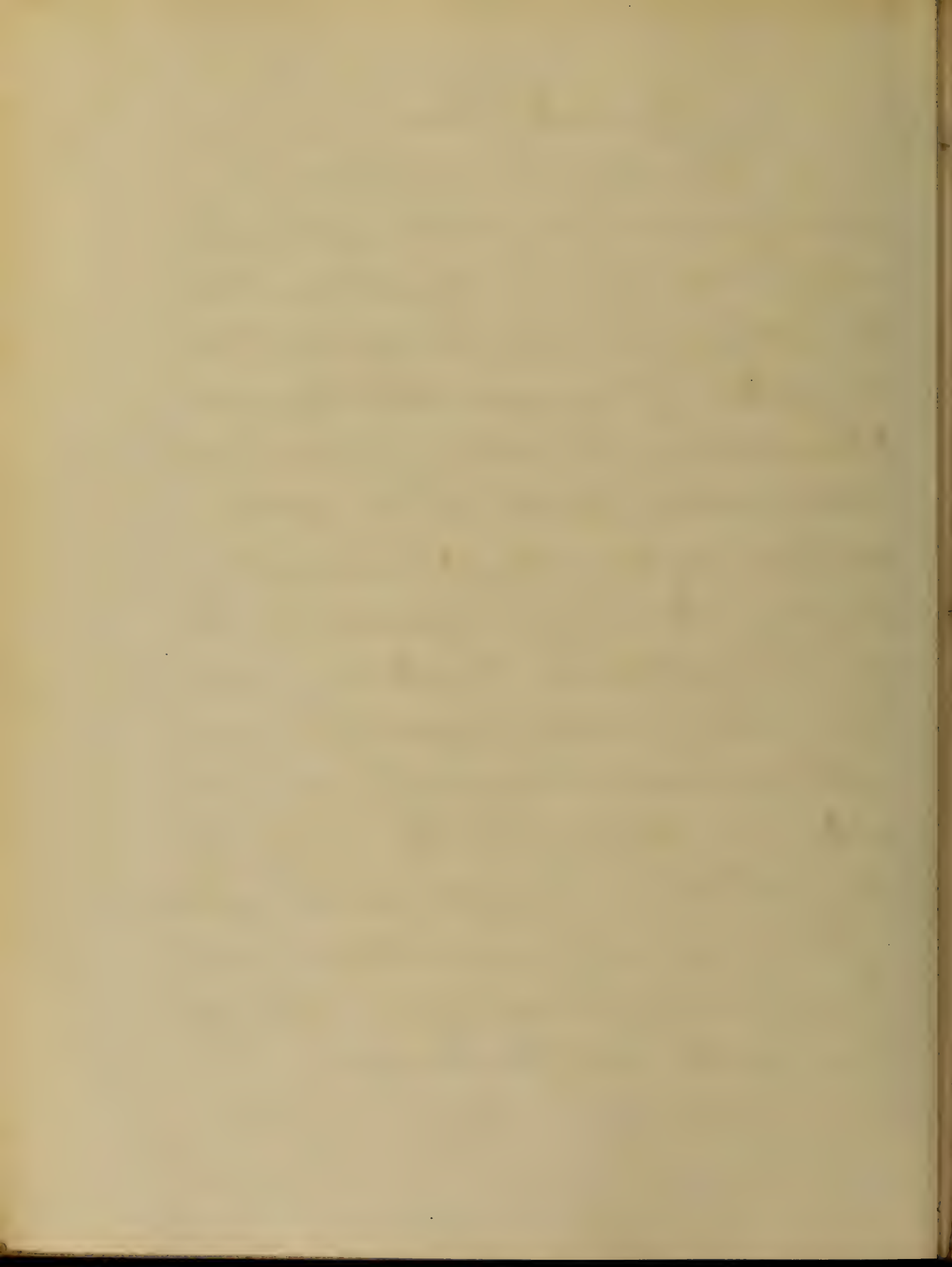
An
Inaugural Dissertation
On the Report
of six cases
Respectfully submitted for Examination
to the Provoost, Regents, and Faculty
of Physic
of the University of Maryland

For the Degree
of
Doctor of Medicine
by
John A. Doerner
of Cumberland
Maryland
Session of 1876-77



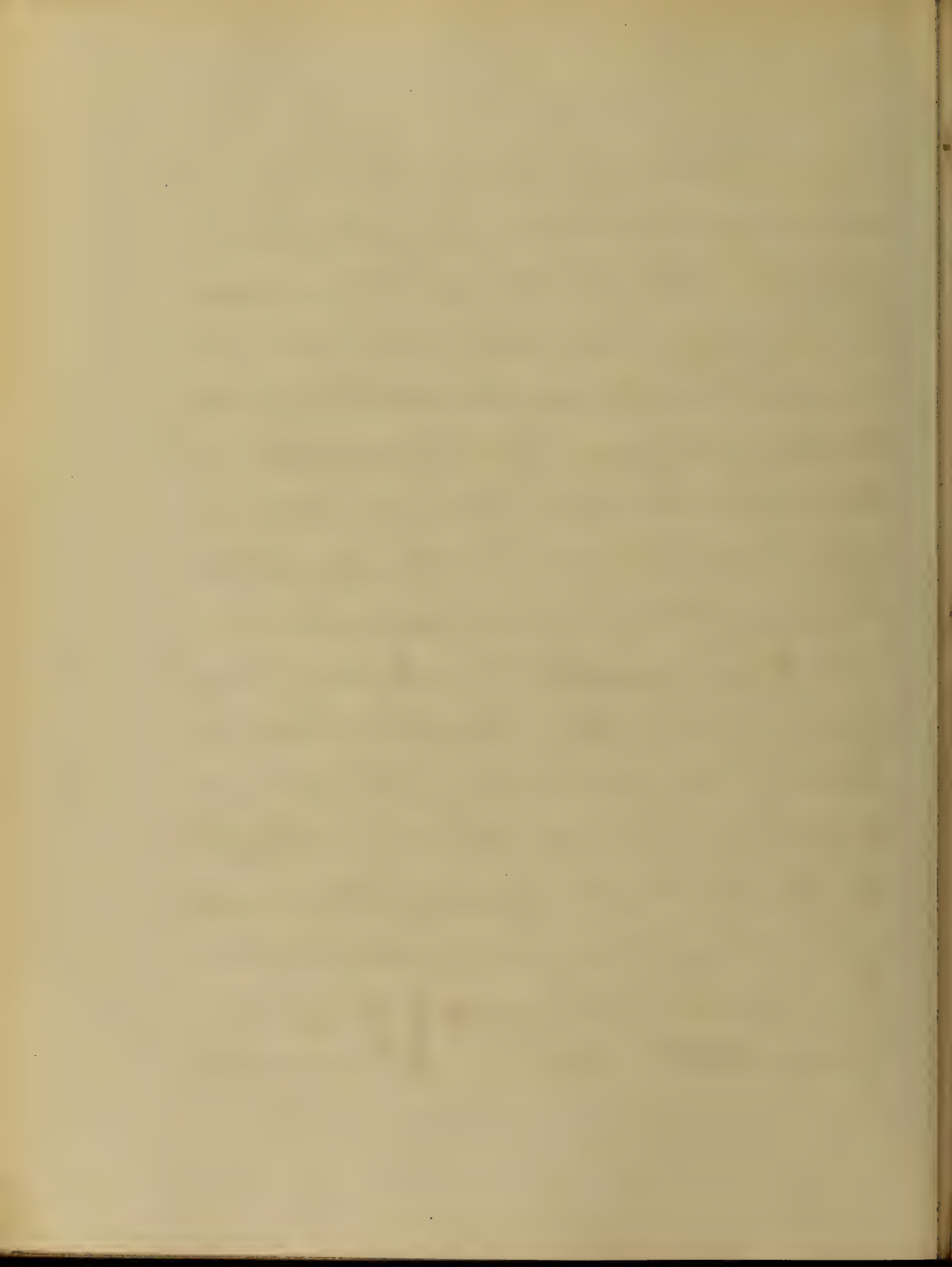
Typhoid Fever

Laura Robinson, a little white girl, age 12 years, of a sallow complexion, red hair, thin and anaemic, residence - Cumberland, Md. She had been well up to Thursday Aug. 3rd, with the exception of being somewhat indisposed to take much nourishment of any kind, and with a total lack of spirits for the last three weeks as regards seeking the company of her playmates. While in Church three weeks ago she fainted. Her Parents are in poor circumstances and consequently her nourishment and general surroundings were inadequate for nutrition. On the morning of Aug. 3rd I was called to see the patient and in making the examination I found her suffering with great pain in the right Iliac region, about the Caecum.

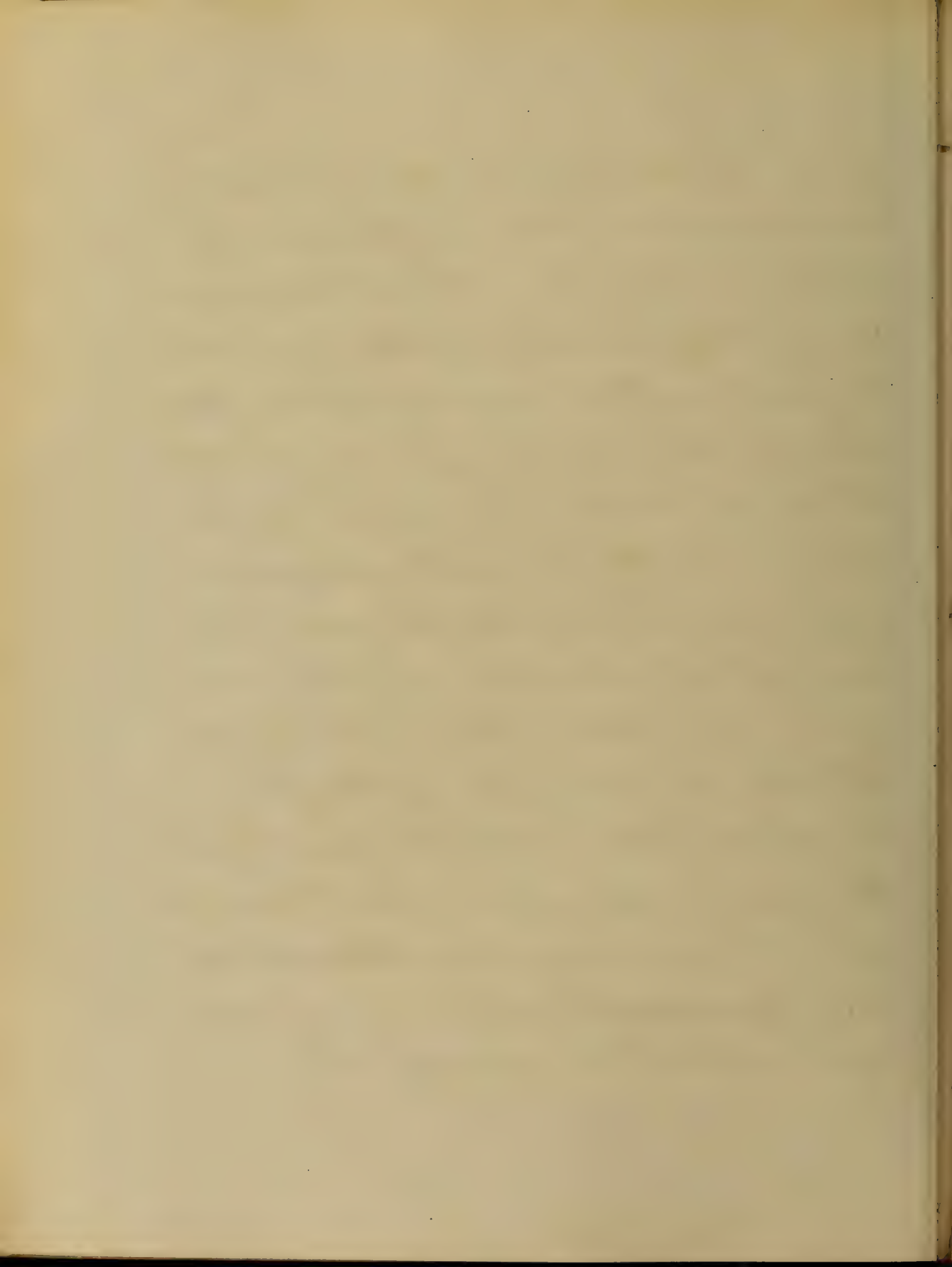


The eyes were suffused, the pulse wiry, and on touching the abdomen she would cry with great pain. Her bowels had not been moved for 3 days previous, and from the localized pain and suddenness of the attack I was led to make a Diagnosis of Intussusception of the bowels. The temperature was $^{\circ}106$, pulse 149 - Respiration 31; from these symptoms it was decided to use Opium, and I accordingly injected, Hypodermically $\frac{1}{8}$ of a grain of Sulphate of Morphia which relieved her of the pain to a great degree; but the pulse and respiration was not affected at all. I left a prescription consisting of the following ingredients - R. -

Morphia Sulphas gr <i>ij</i>	} Sig <i>zj</i> every
Aqua dist. <i>z<i>ij</i></i>	



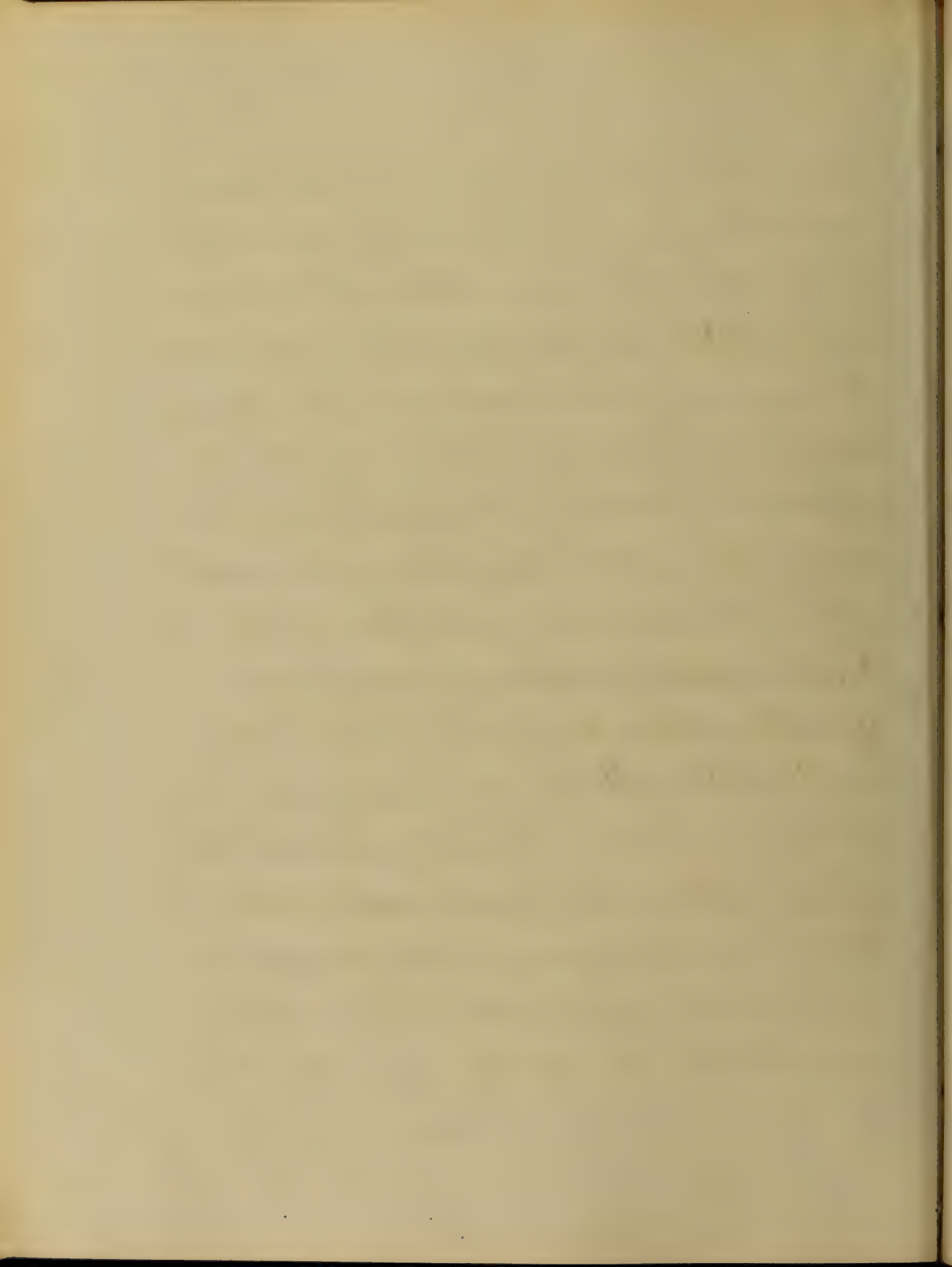
I also ordered Turpentine Stripes to be applied over her abdomen. At 1 o'clock I saw the child again and found the following symptoms - Pupils widely dilated, pulse 150. temperature still 106, respiration about 35. She was not suffering pain to any extent, but when I would run my finger over her abdomen lightly she would give signs of great agony. She would not speak much and did not complain only when one would move her about and I inferred that she was feeling the effects of the Morphia. But in palpating her, I found the disease was general and not localized as in the morning. Her abdomen was very tympanitic and immensely swollen and respiration very difficult.



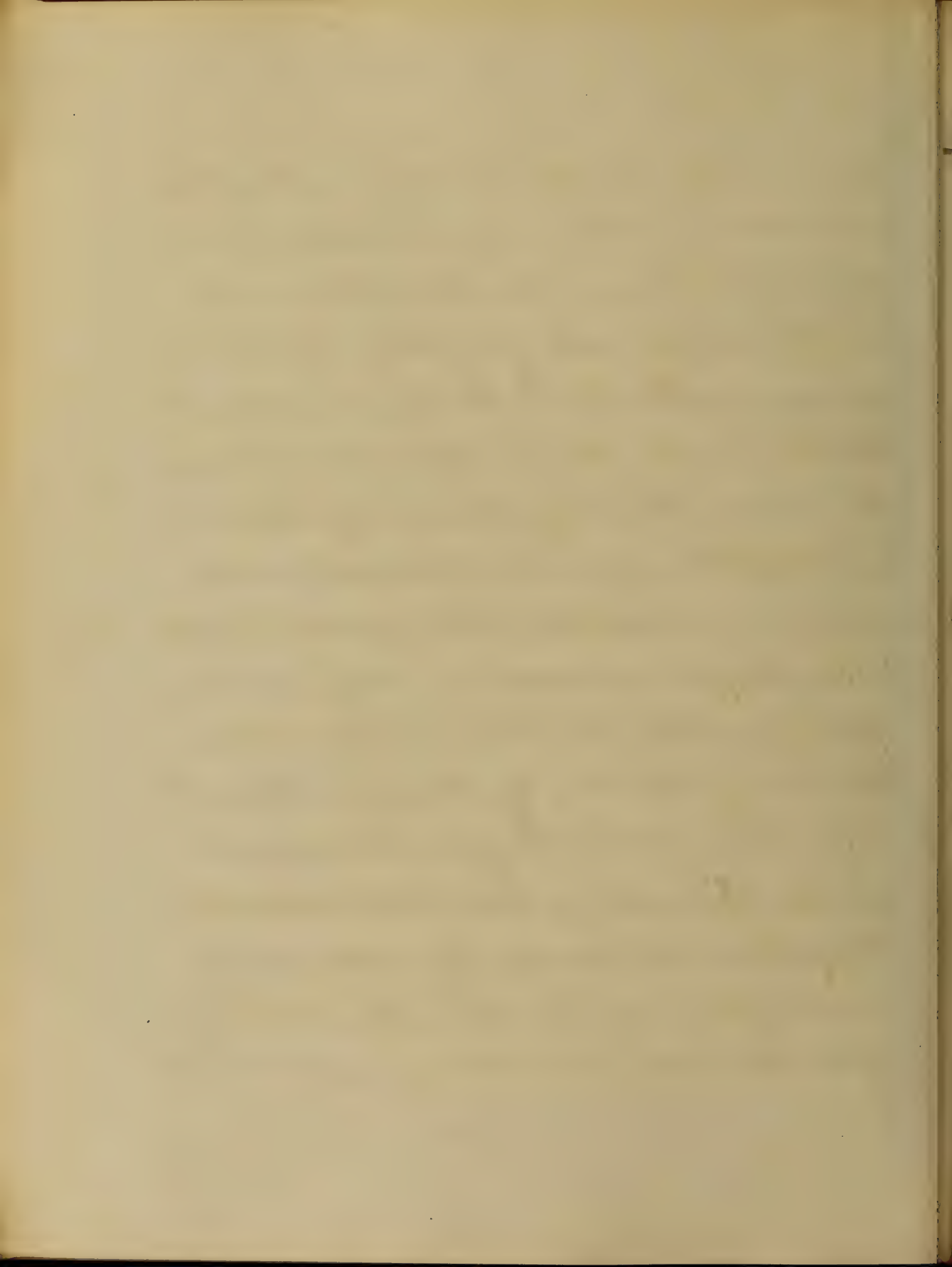
She could pass her urine but had had no evacuation from her bowels for four days, and under the circumstances I left them alone. After a slight pause I concluded it was a very grave case and as the temperature was so high I gave her a Hypodermic injection of M^{xx} Hydro-Bromate of Quinia and continued the M^{m} Morphia by the mouth with instructions to watch it carefully.

I also ordered for her a wine-glassful of milk with a teaspoonful of whiskey in it. I thought it was necessary as her pulse was so weak and quick that the stimulant would be advisable. At 3.

P. M. I called again, and found her very much improved as regards the symptoms. Her pulse was reduced to



136. temperature $105\frac{1}{4}$ respirations 35. She talked more and seemed to be in general better; But on palpation I found the whole abdominal cavity involved and if anything she was more sensitive to the touch. I continued the treatment. At six P. M. I called again the pulse had gone up to 140. Respiration 35 and altogether costal, the abdominal muscles taking no part whatever in the process. Temperature 105 and pain increased exceedingly, caused in part from the fact that vomiting set in, She having had three dejections from the mouth before I arrived. Nothing would remain on her stomach, so that I administered the Morphia and Quinia, Hypodermically, and left her to take the milk and whiskey by the Stomach. I called again at 10.30 P. M.

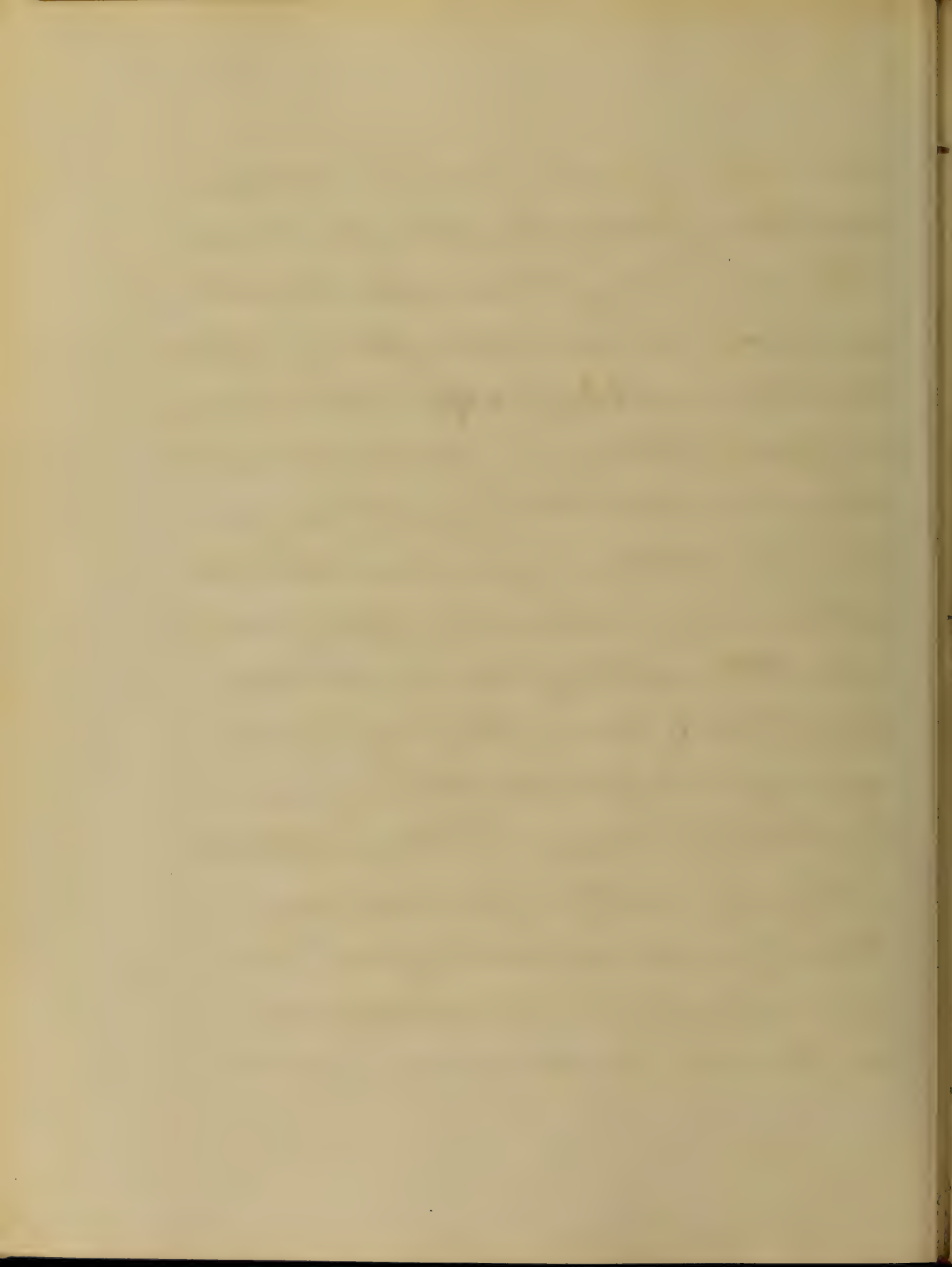


and on arriving was told she was no better. Pulse was still 140, Respiration 34, Temperature $103\frac{1}{4}$ had vomited twice since six o'clock, but had kept 3 doses of milk and whiskey on her stomach. She complained of pain mostly in the Hypogastric region, so that it lead me to suspect the urine could not be discharged. As I had no catheter I sent to my Preceptor, at the same time requested him to come and consult with me. On introducing the catheter after a great deal of trial to me and patient, the urine flowed in abundance, and it gave her marked relief soon after, although she complained and shrieked with more pain just after catheterizing her than before.

I did not see my patient until the next morning at six o'clock. I called the parents



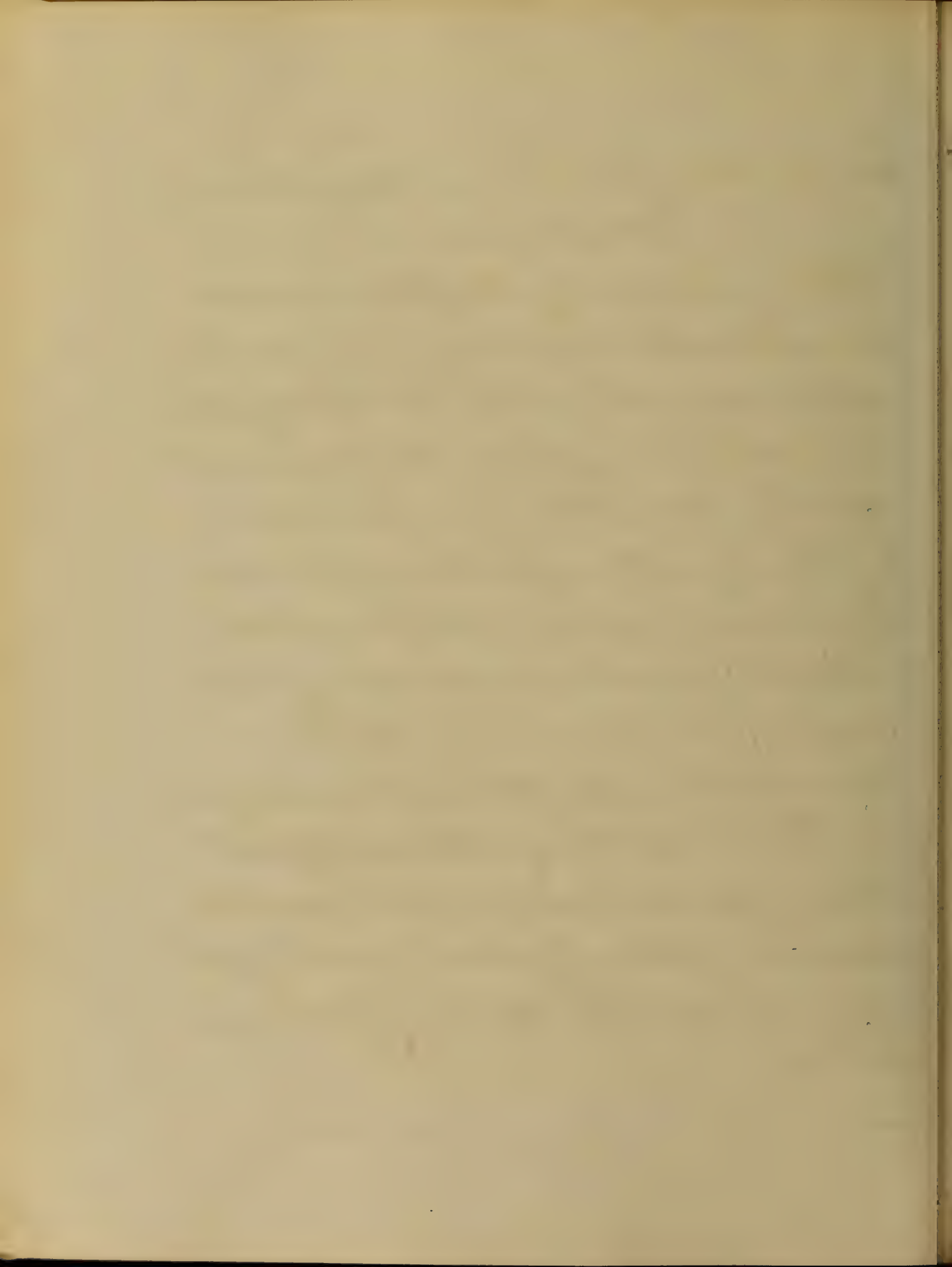
in the adjoining room and informed them
that I thought that the child could not recover
The next morning I was called at about
six o'clock and responded right away. I found
the child in a state of collapse. I at once ordered
mustard plasters to be applied all over the
body, and assisted at it myself, I also gave
Brandy in table spoonful doses but it did
not seem to produce any effect, so acting
on a little hint Prof. Chew gave the class
before I went home I took my Hypodermic
syringe and filled it with brandy and
injected it in the arm. This I repeated twice
with good results, but only temporary
I also gave her carbonate of ammonia
in grains x doses, also used turpentine
on flannel over the abdomen but to no.



avail, for at 8.40 that same morning she died.

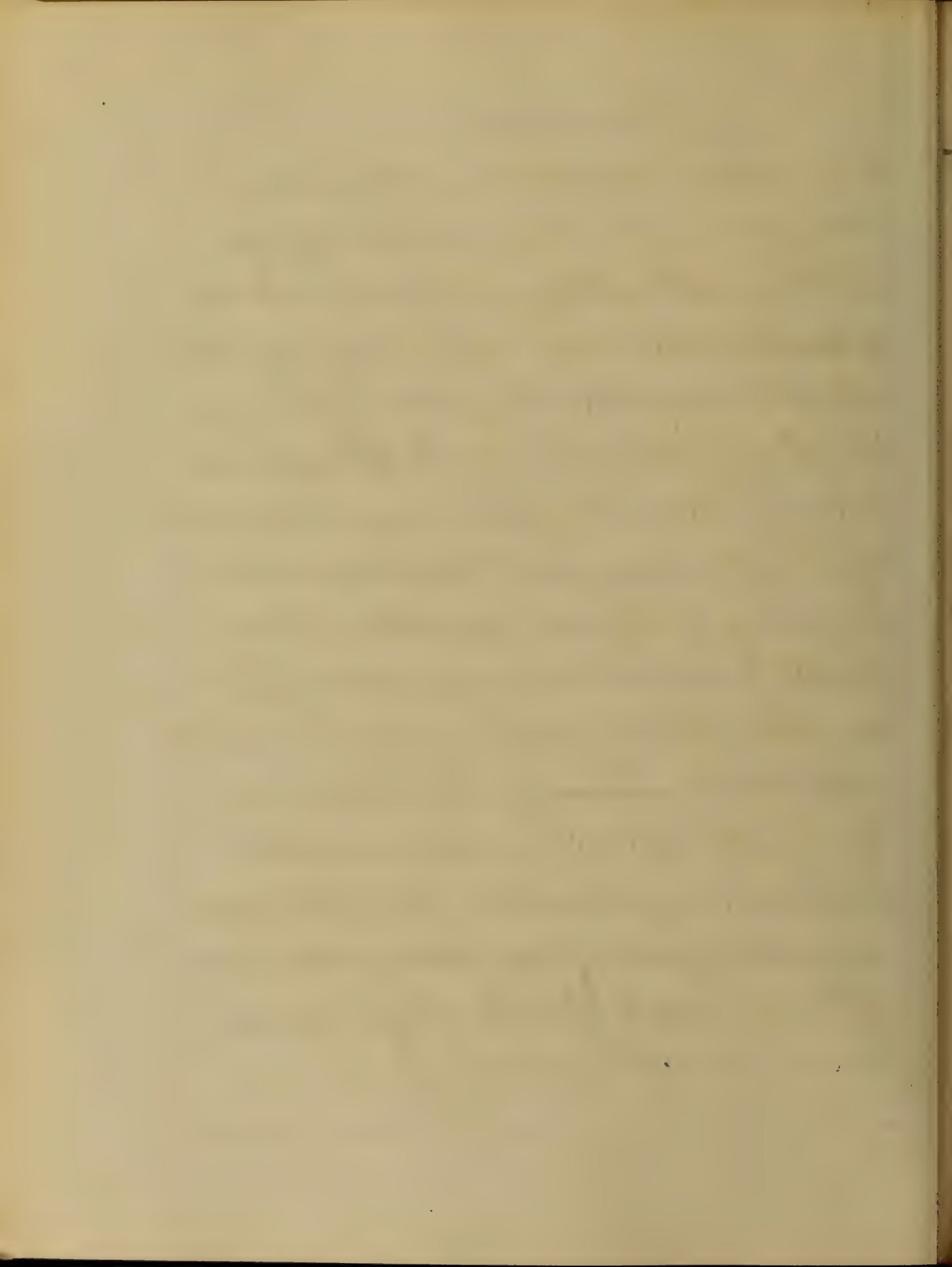
Post-Mortem.

After a good deal of entreaty I was allowed an examination of the body. I found the entire abdominal cavity white with deposits of lymph showing that Peritonitis of a violent character had existed. I searched in vain for Invagination of the bowel, but on taking the gut in my fingers from the stomach to the Rectum I found a round opening about 8 inches from the Caecum in the Ileum. It proved to be an ulcerated Peyer's Patch with perforation. There were 7 other patches in different stages of ulceration, and from this it proved to be a case of walking Typhoid fever. The peculiarity of this case is the absence of febrile exacerbations.

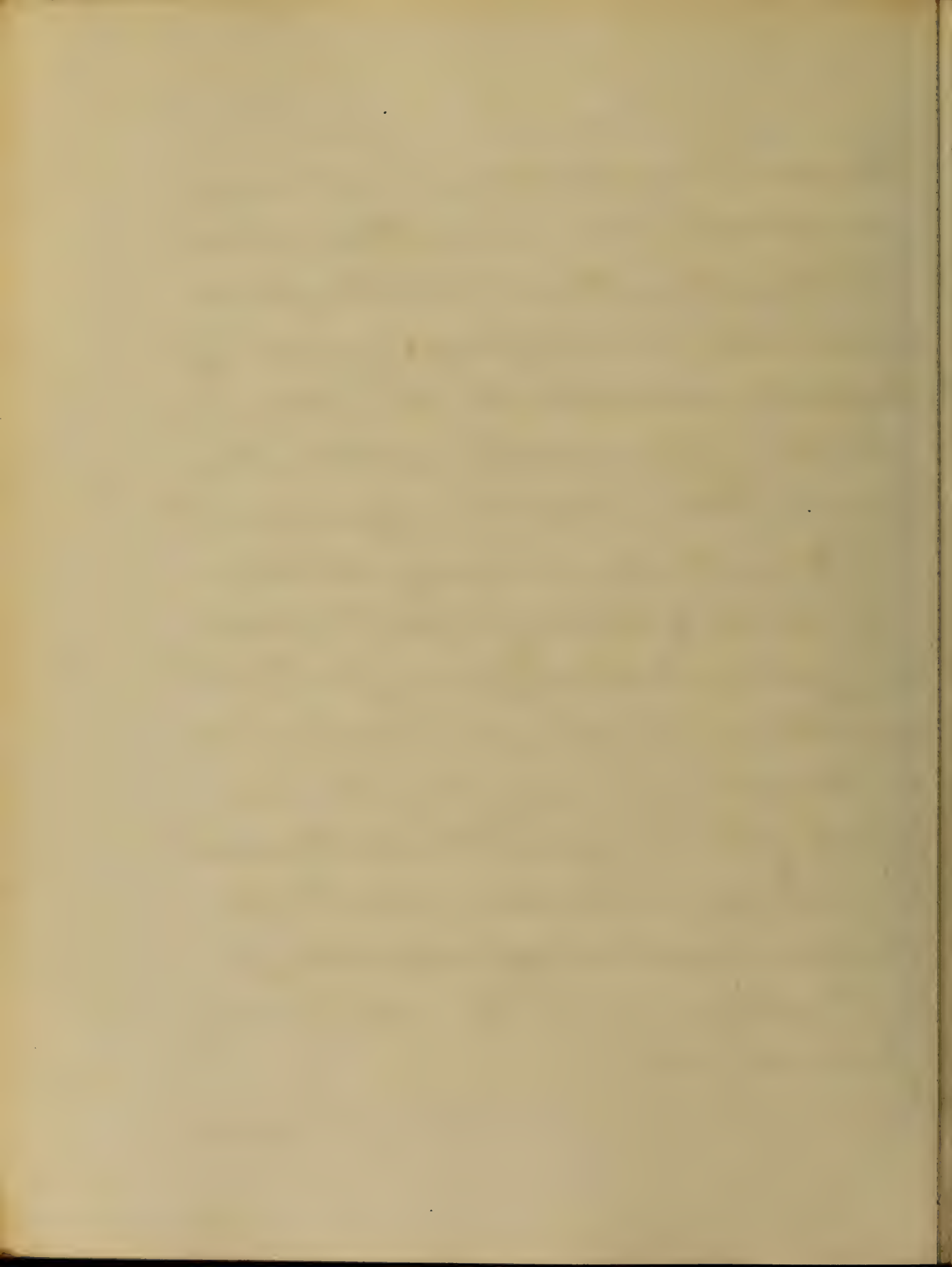


Pneumonia

C. R. aged 32, admitted Dec 29th has been working down the Bay, oyster dredging, was taken with spitting of blood and shortness of breath about 5 days before being admitted into the Hospital. On questioning he complained of great pain in the left side and had a good deal of fever - never had a chill before until 5 days ago, but has had no return. In making a Physical examination it was found he had dulness on percussion from base of the left Lung to the very apex in front and behind, absence of vesicular murmur, Bronchial respiration and a marked brick-dust expectoration, from which signs along with a pulse of 103 and temperature 104 it ^{was} clearly evident that the Diagnosis was Pneumonia of the left Lung.



Was ordered Dover's powder gr^v; next morning
was ordered Ligu. Ammoniac acetatis ʒss every 4 hours.
The temperature went up to 105°⁴ that night and
he was ordered Quinia Sulphas gr^x; next morning
temperature was 101. He felt much better and
did not cough so much, the expectoration having
become whitish and resolution begun. Jan 3rd
continues to improve rapidly, but there is
a good deal of dulness from the 7th rib down
owing to a pleuritic effusion. Jan 5th & 6th
condition very much improved the dulness
is disappearing very much in the lower
part of the lung, while the vesicular murmur
has returned as low down as the 8th rib.
He has improved steadily and is to-day Jan
20th walking around the ward appearing
fresh and well.



106 Record of Vital Signs

Temperature

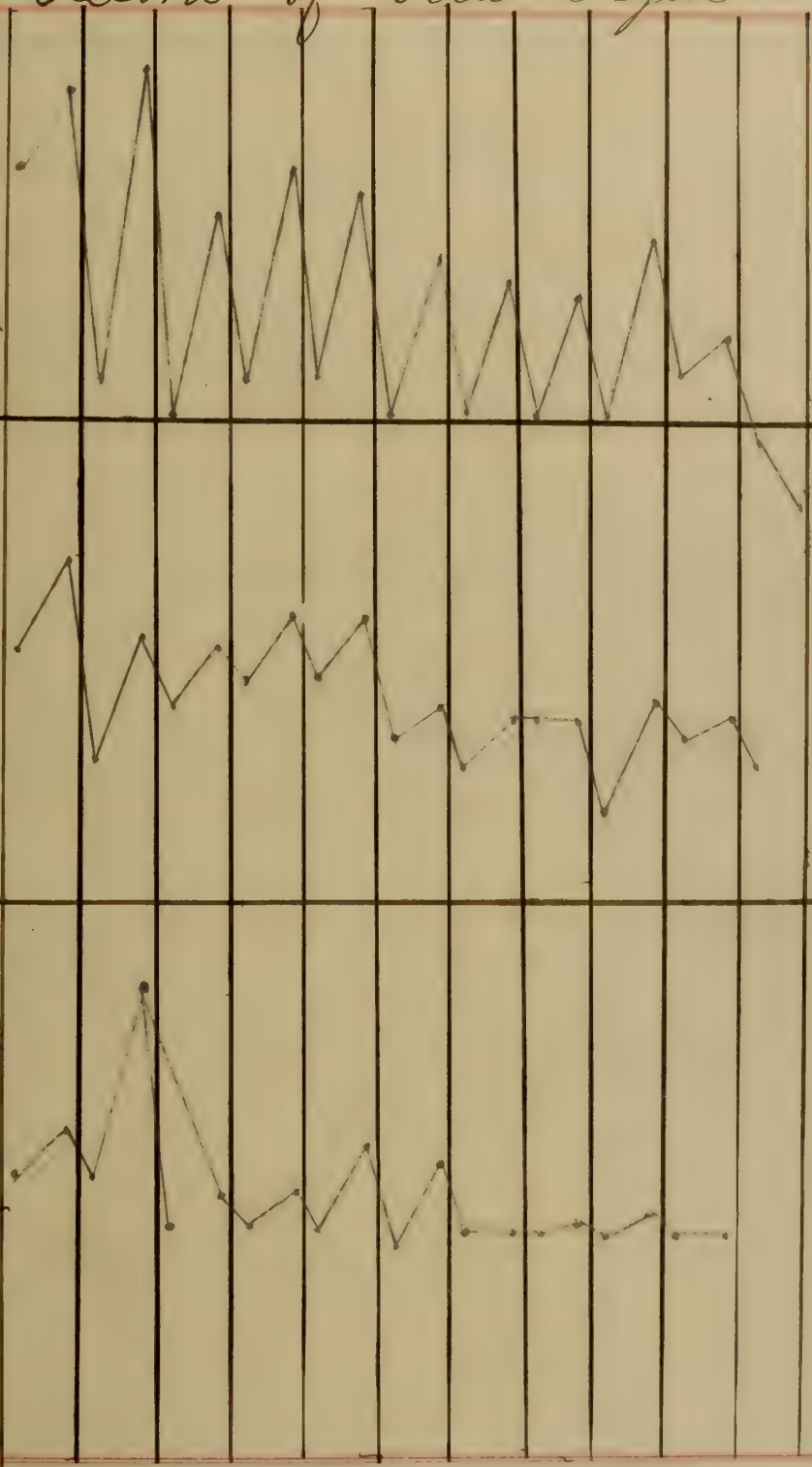
105
104
103
102
101

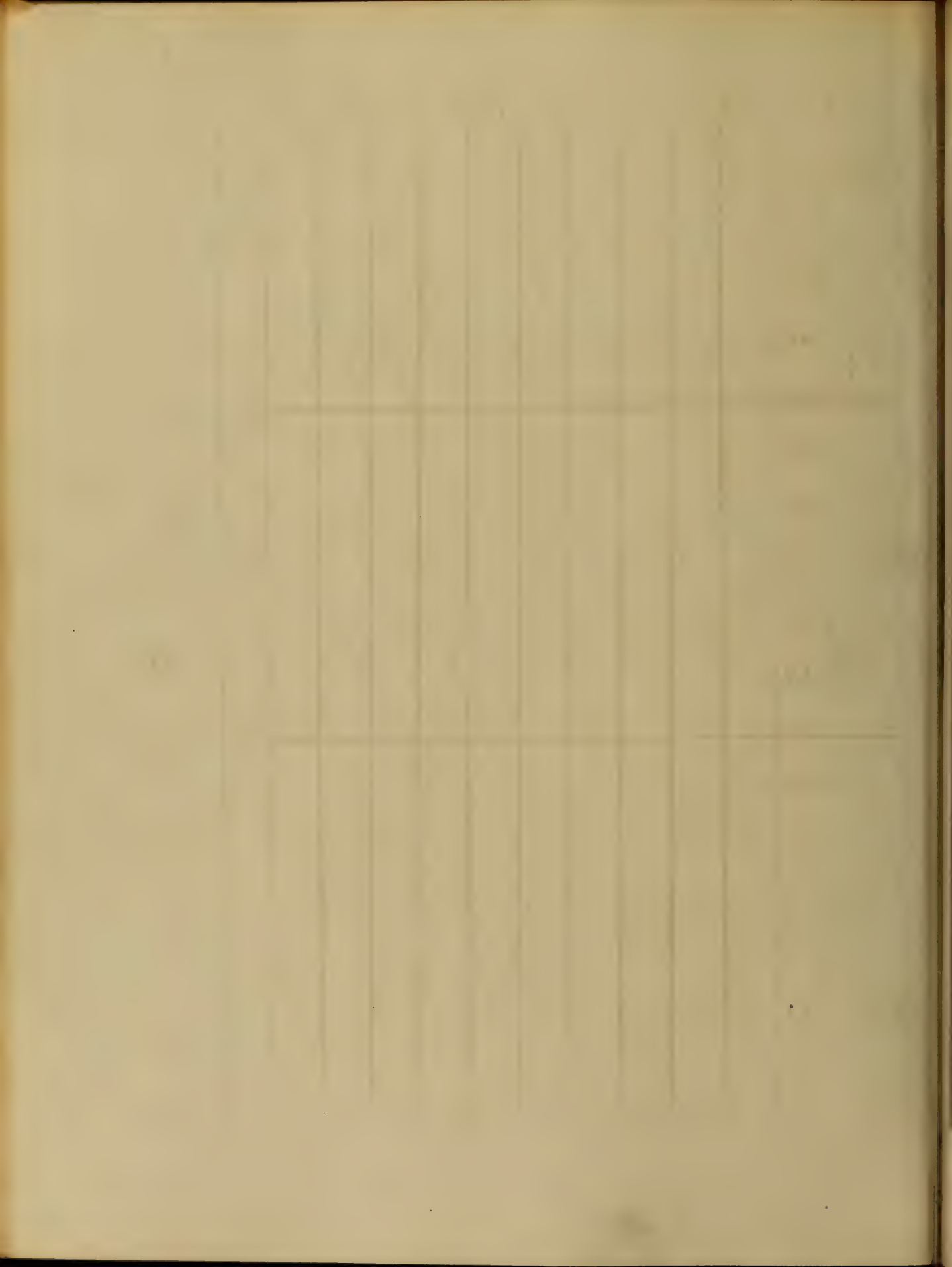
Pulse

120
110
100
90
80
70

Respirations

40
35
30
25
20
15
10





An Inaugural Dissertation

on

Digestion and its Derangements

Submitted to the Examination

of the

Procurator Regents and Faculty of Physic

of the

University of Maryland

for the

Degree of Doctor of Medicine

by

Thomas P. McSwain

of

Louisiana

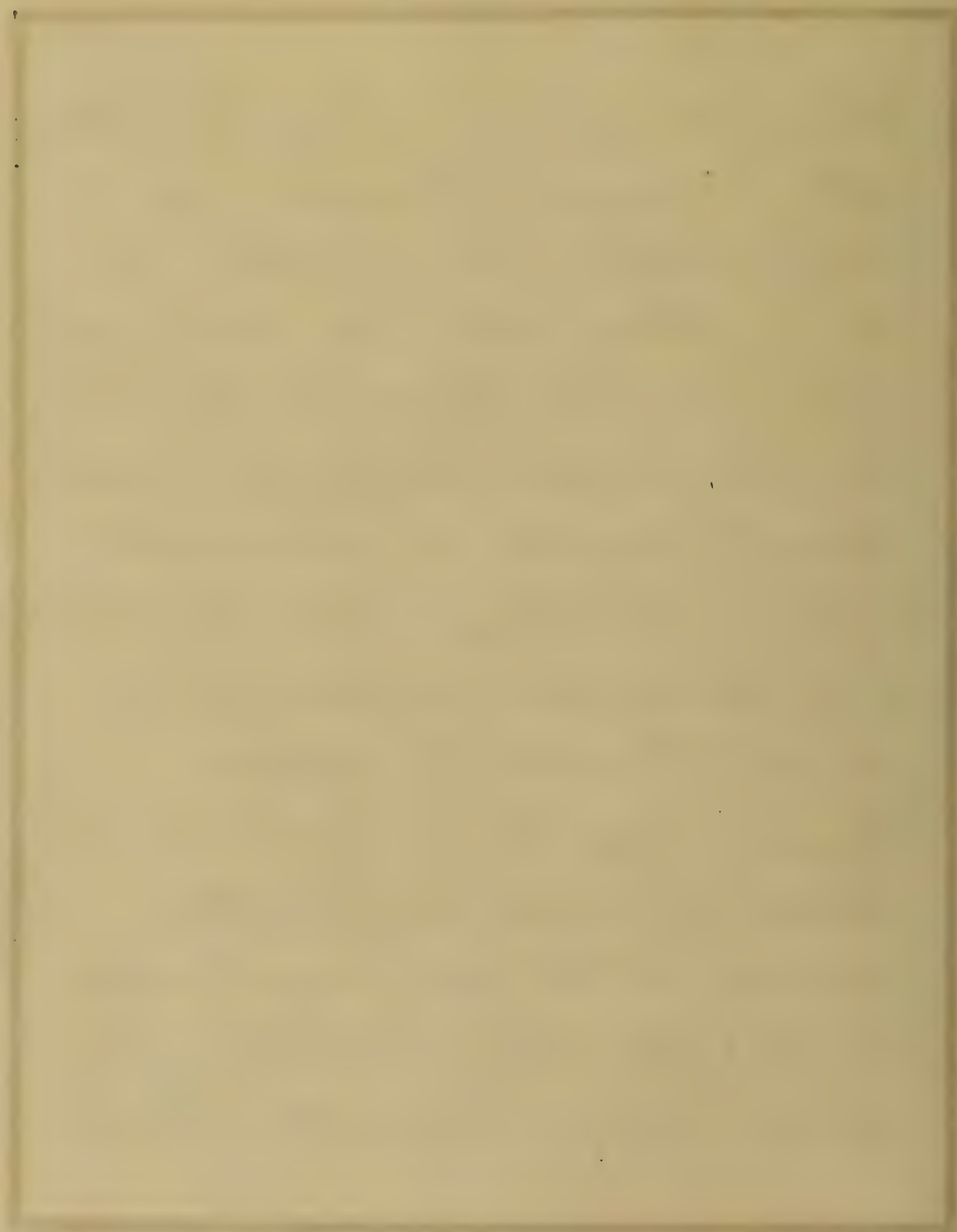


Having chosen so fruitful a subject for my Thesis I do not expect to treat any part of it with more than a cursory glance; Happy would I be if I could take one single part of my subject and advance some new ideas on it; but, in the present very primitive state of my knowledge, I shall have to be content with a compilation from the works of others.

"Digestion," to use the language of Professor Dalton, "Is that process by which the food is reduced to a form in which it can be absorbed from the intestinal canal and taken up by the bloodvessels."



And a most wonderful process it is! Nine tenths of humanity know nor care nothing about the way in which their life is sustained; some have a dim sort of an idea that they must eat to live; but that is nature's teaching for the most ignorant of us feel an indescribable craving and weakness about the stomach if we do not answer nature's calls for more fuel to supply the furnace. Digestion begins in the mouth at the moment of prehension of the food; mastication is the first process to which it is subjected; during mastication the food is thoroughly incorporated with saliva.



which forms the bolus into a semi solid mass and facilitates deglutition; the saliva also exerts a peculiar chemical action on the starchy ingredients of the food changing the starch into Glucose. This change is only partial, however and does not always take place, the principal function of saliva being to facilitate the passage of the bolus from the mouth through the oesophagus into the stomach, where the great work of digestion begins in earnest. But the saliva exerts considerable influence on the sense of taste; we all know if we put a lump of sugar into the mouth



that we do not appreciate the taste until the saliva begins to dissolve the sugar; ^{and} so it is with other hard substances the saliva softens them and aids materially in the taste.

When the aliment reaches the stomach it excites the flow of gastric juice; for that the gastric juice is not always present in the stomach has been shown by the researches of Physiologists, and in the healthy stomach the flow ought only to be excited by the actual presence of food, although the fluid has been caused to flow by the mechanical irritation of a canula



introduced through a gastric fistula. Why the stomach should be excited to its work by the presence of food is not thoroughly comprehended, but I think can be explained in this way: the nervous system is the first to recognize the presence of the bolus and by some wonderful method, the nerves cause an increased flow of blood to the walls of the stomach and the digestive fluid is secreted from the blood by the gastric follicles.

The gastric juice consists of a free acid, and an albuminoid matter



Known as Pepsin, besides water ^{and} a number
of the earthy salts held in solution.
The following is the composition of
Gastric juice according to the best
analysis.

Water	975.00
Free Acid	4.78
Pepsin	15.00
Sodium Chloride	1.70
Potassium	1.08
Calcium	0.20
Ammonium	0.65
Lime Phosphate	1.48
Magnesium	0.06
Iron	0.05
	<hr/>
	1000.00



But the ingredients of the gastric juice do not exist invariably in the same proportion as given in the foregoing table; they certainly vary very much in diseased conditions and even in health in different individuals.

The most notable physical property of the gastric juice is its acid reaction, by which it is distinguished from all the other digestive fluids. Whether this acid is Lactic, or Hydrochloric, is still a question.

There are a number of Physiologists on each side; which party is right is hard to decide.



The next most important ingredient of the gastric juice is Pepsin, this is a neutral or alkaline substance always found in the stomach. Pepsin will not act alone but requires for its action upon the food the presence of a free acid; pepsin can be precipitated from solution by heat or alcohol in excess. Alcohol is very destructive to the action of the gastric juice by throwing down its pepsin in an insoluble state; The vomiting after a debauch is caused by the alcohol having precipitated the pepsin and so rendering the gastric



juice inert; the food remaining in the stomach undigested soon acts as a foreign body and is thrown off by a wise provision of nature.

There is no doubt that a small quantity of spirit increases the appetite and improves digestion by causing an increased flow of gastric juice, but, taken habitually, and in large quantities, it is very hurtful to the system.

Another peculiar property of gastric juice is its power of preventing decomposition. All the other animal secretions putrefy with the greatest



readiness, but the gastric juice when exposed to the air remains for many months without developing any putrefactive odour it will even arrest putrefactive changes when they have already begun in other organic matters. A certain degree of heat is also essential to the proper action of gastric juice; a piece of meat immersed in gastric juice which is below the normal temperature of the body will not show any signs of digestion at the end of an hour; but if the heat be increased to between 98° and 100° the gastric juice will exert its characteristic properties



During active digestion the temperature is thought to be higher than during repose. Thus the temperature of a stomach in repose ranges between 98° and 100° during digestion it is increased to about 102° .

The habit of eating ice cream and water ices after meals undoubtedly retards digestion by lowering the temperature of the stomach. The quantity of gastric juice secreted by a healthy man in the twenty four hours has never been determined, nor do I see how more than an approximate estimate can be made; for the food



which is more difficult of digestion requires a larger quantity of the gastric juice to act upon it, then again there are some aliments which excite the stomach to increased action by their stimulating influence that there is an intimate connection between the mind and digestive apparatus is well shown by the fact that any mental agitation such as anger, joy, or sorrow will interfere with the appetite and subsequent digestion, The loss of appetite which nearly always precedes serious illness of any kind is a warning from nature not to give the stomach



any more work than is absolutely necessary. The time required for the digestion of a hearty meal varies according to the state of the digestion, and the matter to be digested, if the food is well masticated, moderately digestible, and all things being favorable, it is generally thoroughly digested at the end of three or four hours. The gastric juice is reabsorbed with the digested substance after it has accomplished its work. The reabsorption goes on simultaneously with the secretion; that is, as the food is digested it is carried into the intestine and a certain amount of the gastric



juice flows along with it so that the gastric juice does not accumulate in the stomach. Let us follow the aliment from the stomach into the intestine and see what sort of a change it is subjected to there.

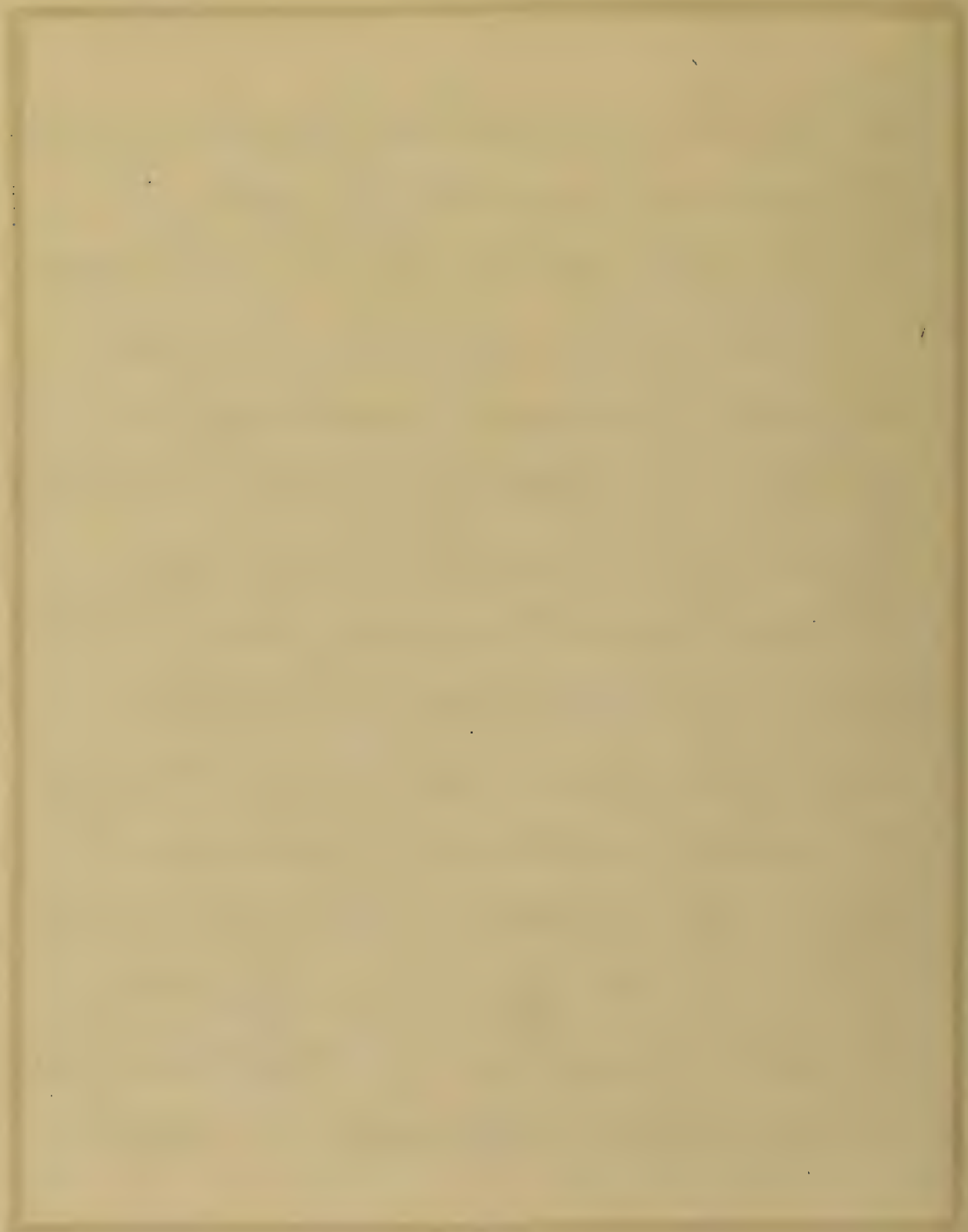
When the food enters the duodenum the fatty and starchy ingredients still remain to be digested, as the gastric juice only possesses the power of digesting the albuminoid matters and converting them into a substance called albuminos. In the duodenum the food is brought in contact with three different secretions the bile, the pancreatic juice, and



the secretions of Brunner's duodenal glands.
The pancreas resembles the salivary glands in its general structure; it secretes a peculiar juice which is clear and colorless, of a viscid consistency and alkaline reaction; it is said to resemble the uncoagulated white of an egg.

Pancreatine is the name given to the most important ingredient of the pancreatic fluid; about one tenth of the whole secretion is pancreatine.

It is this substance which gives the fluid its viscosity; it is coagulated by heat, by alcohol, by nitric acid, also by Sulphate of Magnesia in excess.



it differs from albumen in being coagulable by Sulphate of Magnesia, as albumen is not coagulated by this latter substance. The pancreatic juice has the power of transforming starch into sugar; an action which takes place very quickly at the normal temperature of the body. The pancreatic juice also has the power of emulsifying the fats which power is of the greatest importance in the digestion of fats; as the fatty particles are only melted in the stomach, but when the oily portion of the food comes in contact with the pancreatic juice it is emulsified.



and converted into a white opaque looking substance which is easily absorbed; this emulsified substance is called chyle.

The pancreatic juice is also said to possess to a limited degree the power of slowly dissolving coagulated albuminous matters.

The quantity of pancreatic juice secreted in a day is not known, but most observers agree that it is small in comparison with the secretions from the liver and stomach; Like the gastric juice it is only when its presence is required that the pancreatic juice is secreted.



The intestinal juice is the product of the secretions of two sets of glands, Brunner's, and Lieberkuhn's; it has been found a very difficult matter to obtain the secretions of the intestinal glands in a separate state; Brunner's glands resemble the pancreas in their minute anatomy, and their secretions are supposed to bear some resemblance to that of the pancreas both in appearance and action.

Lieberkuhn's follicles are found throughout the whole length of both the small and large intestine, they consist of small straight tubes thick



set in the mucous membrane, and opening perpendicular to the mucous surface.

There must be an immense number of them in the intestinal tract, their secretion forms the largest part of the intestinal juice, nothing definite is known in regard to the quantity of the secretion of Lieberkuhn's follicles, but in quality it is a clear colorless, alkaline fluid, possessed with the power of actively transforming starch into sugar. In regard to the secretions of the solitary and agminated glands very little is known; they are closed sacks having no visible outlet; they are found



to be filled with a soft, pulpy, semi-transparent mass, and are larger during digestion than fasting, what they contain must be regarded as a product of secretion but for what purpose is not thoroughly understood: Solitary glands have been said to give the characteristic odour to the feces.

Peters patches which are made up of solitary glands, bunched together, must perform some important function in disease or health, else they would not play so important a part in Typhoid fever.



Having followed as well as we could the alimentary bolus through all its transformations, and seen the way in which digestion takes place from the stomach throughout the entire length of the small intestine; let us see if we can follow the digested material on its way to make blood. All the albuminoid substances are changed into albuminose; the fats are converted into chyle, and the starch is transformed into glucose.

As the liquified mass passes down the intestine it comes in contact with the absorption apparatus of the intestine; this consists of millions of little



villosities which line the whole length of the small intestine and give it that smooth velvety feeling; these villi are most abundant in the duodenum and jejunum. Each villus is covered with cylindrical epithelium similar to that lining the intestines from the cardiac orifice of the stomach; The villus is penetrated from below by capillary blood vessels supplied from the mesenteric artery; it is also pierced through its center by a lymphatic vessel. The blood vessels are supposed to absorb all the albuminose, glucose and molecular fat and take it through



the portal circulation to the liver.

The lacteals absorb the chyle and take it through the intestinal lymphatic system to the receptaculum chyli from whence it is conveyed through the thoracic duct to the left subclavian vein where it enters into the general circulation; The fat generally disappears from the blood in its passage through the lungs, but if the quantity of fat consumed be large it does not entirely disappear with the passage of the blood through the lungs but is found in the general circulation, This state of affairs has been found to exist in



the blood after death from Apoplexy
occurring after a full meal; It is a
condition perfectly consistent with health
however and is due to the chyle being
absorbed from the intestine faster than
it can be appropriated by the different
tissues of the body. The lower part
of the colon and rectum must possess the
power of absorption, else how would
suppositories and nutrient enemata act?
That they do act is proven beyond
a doubt, as persons have been kept
alive for weeks with beef tea and
other nutritious substances administered
by the rectum when the stomach



was unable to digest any thing.

The process of absorption is greatly aided by the peristaltic action of the intestines.

The portal circulation conveys all the other products of digestion from the stomach, pancreas, and intestinal tract to the liver. Exactly what are the functions of the liver has not yet been definitely ascertained; we know that certain changes in the products of digestion take place in the liver, but there is less known about the action of that organ than any other important organ pertaining to the body.

The liver is supplied with both



arterial and venous blood at the same time: The Hepatic artery and the Portal vein. The Hepatic artery supplies the walls of the hepatic ducts, those of the portal vein, the capsule of Glisson, and the peritoneal covering of the organ; while the Portal vein ramifies in the glandular parenchyma of the organ. The Hepatic artery evidently supplies the blood for the nutrition of the liver, and the portal vein must carry the products of digestion for the liver to work on.

The — bile which is the product of secretion of the liver, differs from the other products of glandular secretion by

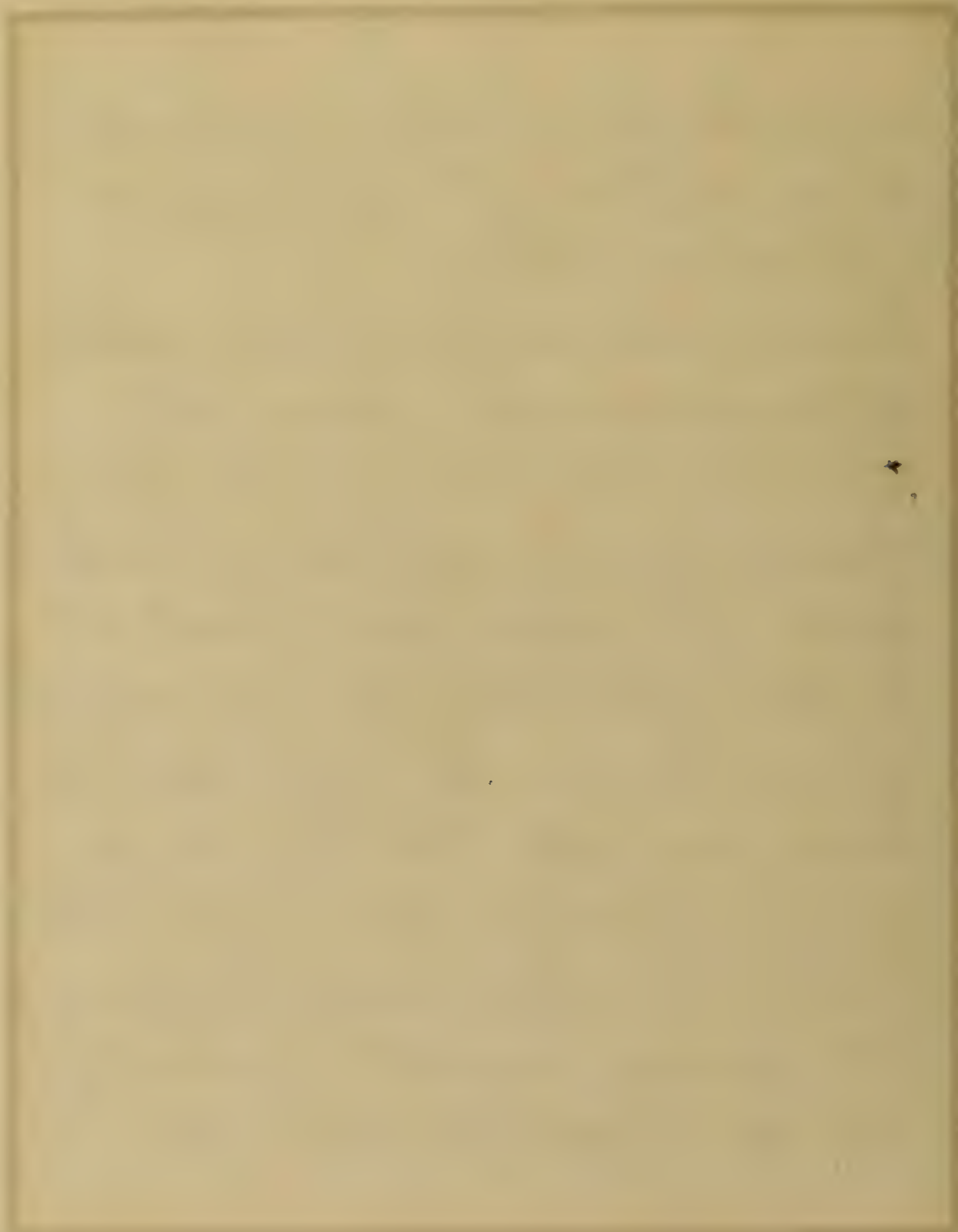


not containing any albuminous ingredient similar to those of the salivary glands, pancreas, or intestine.

Bile is made up of nitrogenous crystallizable substances and coloring matter.

The bile as it flows from the gall bladder is a clear rosy fluid of a neutral reaction; the specific gravity is said to be about that of healthy urine, varying from 1018 to 1024. It is of a yellowish-bronze green color; the color may be changed by oxidizing agents; By transmitted light the bile has a variety of colors.

The two most important ingredients of bile are Glycocholate of soda and

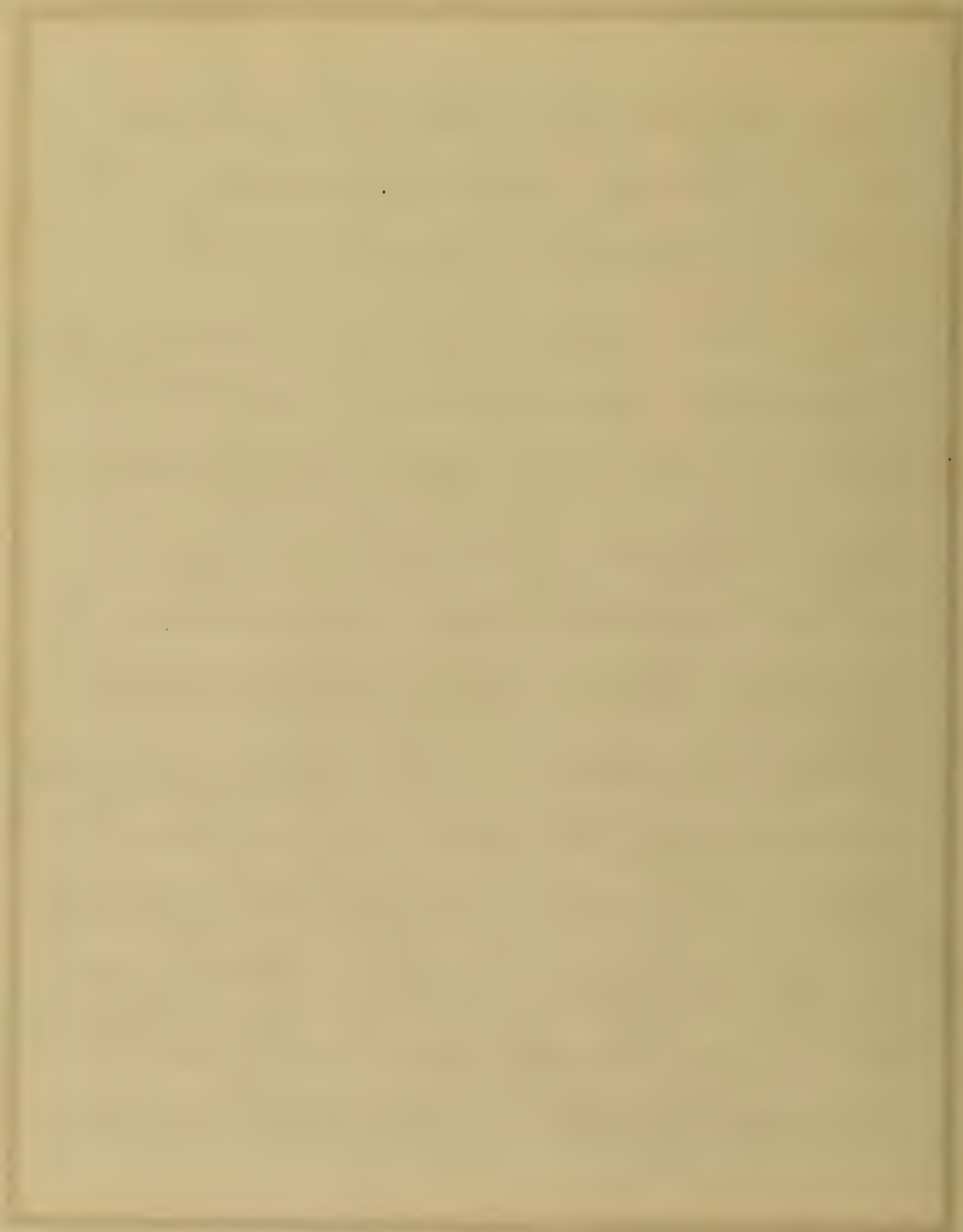


Taurocholate of Soda; they are produced in the substance of the liver; bile is constantly being secreted by the liver but the secretion is more abundant a few hours after meals than at any other time.

Bile must be regarded as a secretion having several purposes to fulfil, first as an excretion, second as a secretion containing elements for reabsorption thirdly as a secretion affording assistance in the digestive process. It is the coloring matter of the bile that is excreted. There is nothing to show that the bile exerts any digestive influence upon the various ingredients of the food.



It is thought that the bile acts as a stimulus to the glandular follicles of the intestines; I should not wonder if there was some truth in this belief; it is also thought to facilitate the absorption of fat by the lacteals but I do not exactly see how this can be. By far the largest part of the bile is reabsorbed and carried back to the liver through the portal circulation, there to be reformed and begin its mysterious round again; the bile does not reach the liver in the same state as that in which it left through the gall bladder; in fact it is bile no longer as it cannot be recognized in the portal blood by any



of the biliary tests, it must therefore perform some duty in the intestine that changes its entire nature.

As all the products of digestion except the emulsified fats pass through the liver before they reach the general circulation, the liver must perform some very important part in the economy of the body; but exactly what are these functions remains for some one to discover.

Although a great deal of time and learning has been devoted to the subject of intestinal disorders; there is often considerable difficulty experienced in diagnosing gastric disorders; when there



is no actual tumour to be felt we can not feel the walls of the stomach like we can an enlarged liver or spleen. nor can auscultation and percussion be relied on, as the intestines are within certain limits moveable, and one might think he was auscultating the stomach when it would be the colon or some other part of the intestine.

Having seen how the process of digestion takes place we ought to be able the more fully to appreciate any deviation from a healthy and easy process; for healthy digestion takes place without giving any sign of the work that is

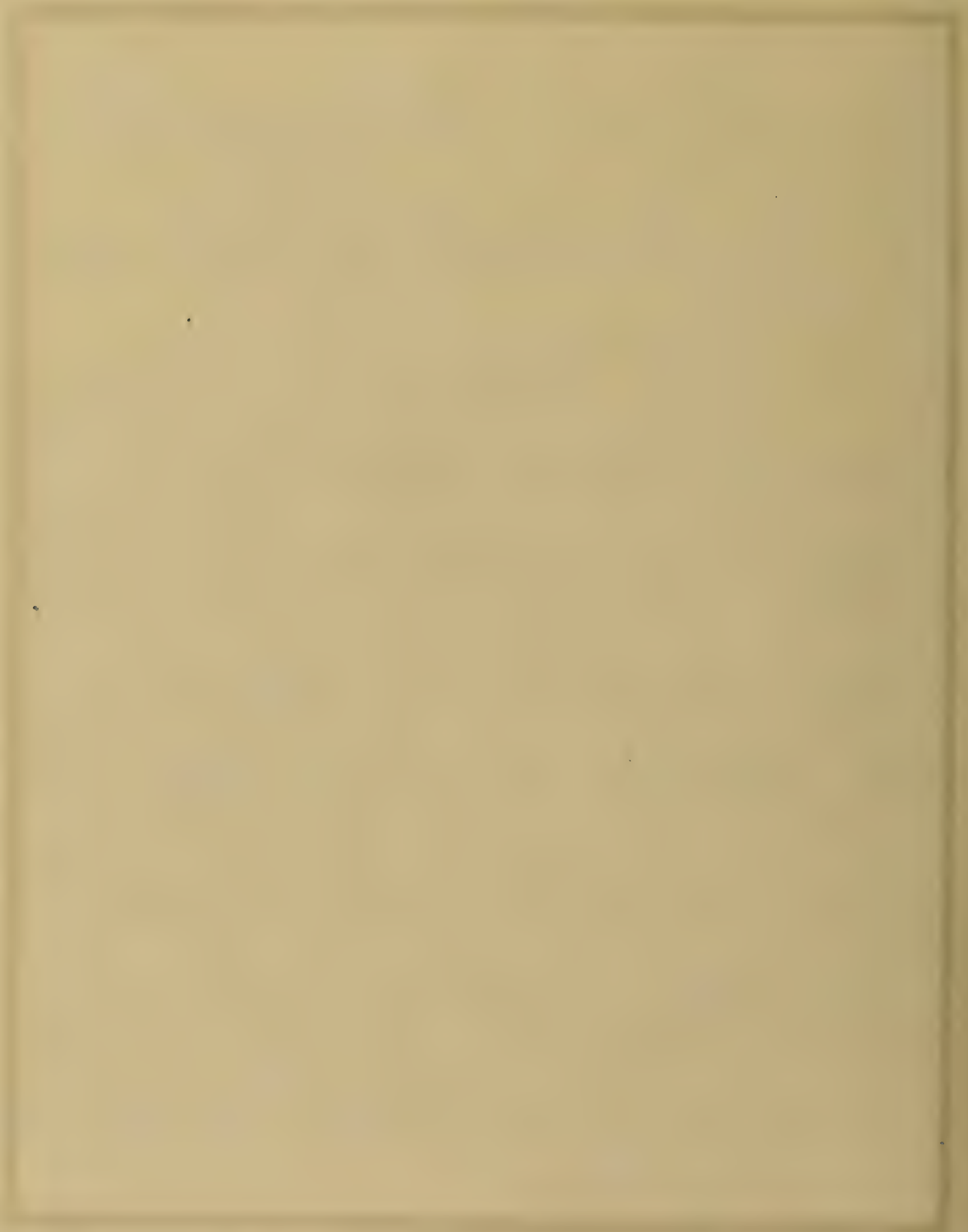


proceeding; it is only when there is any
thing out of order with our digestive
apparatus that we are made aware that
such a process as digestion is going on
within us. There can be little doubt
but that the maintenance of the
integrity of the digestive organs is the
best prophylactic measure against disease.
What a terrible fix is a person in, if
he lose the power of assimilating food:
all the rest of his body may be strong
and healthy; but if he can't digest he
must gradually wither and die.
Until within a few years all medicines
as well as aliments had to be given by



the mouth or rectum, but now thanks to the hypodermic syringe patients can frequently be medicated without the aid of the stomach.

Let us look to some of the predisposing causes to disordered digestion; first is excessive mental occupation with sedentary habits; then if a person is morose and cross, eats all his meals alone and is very particular what he eats his digestion will not be so good as that of the man who is always eating with his friends and laughs and talks during his meal showing that it is good for the digestion to be in a cheerful humor.

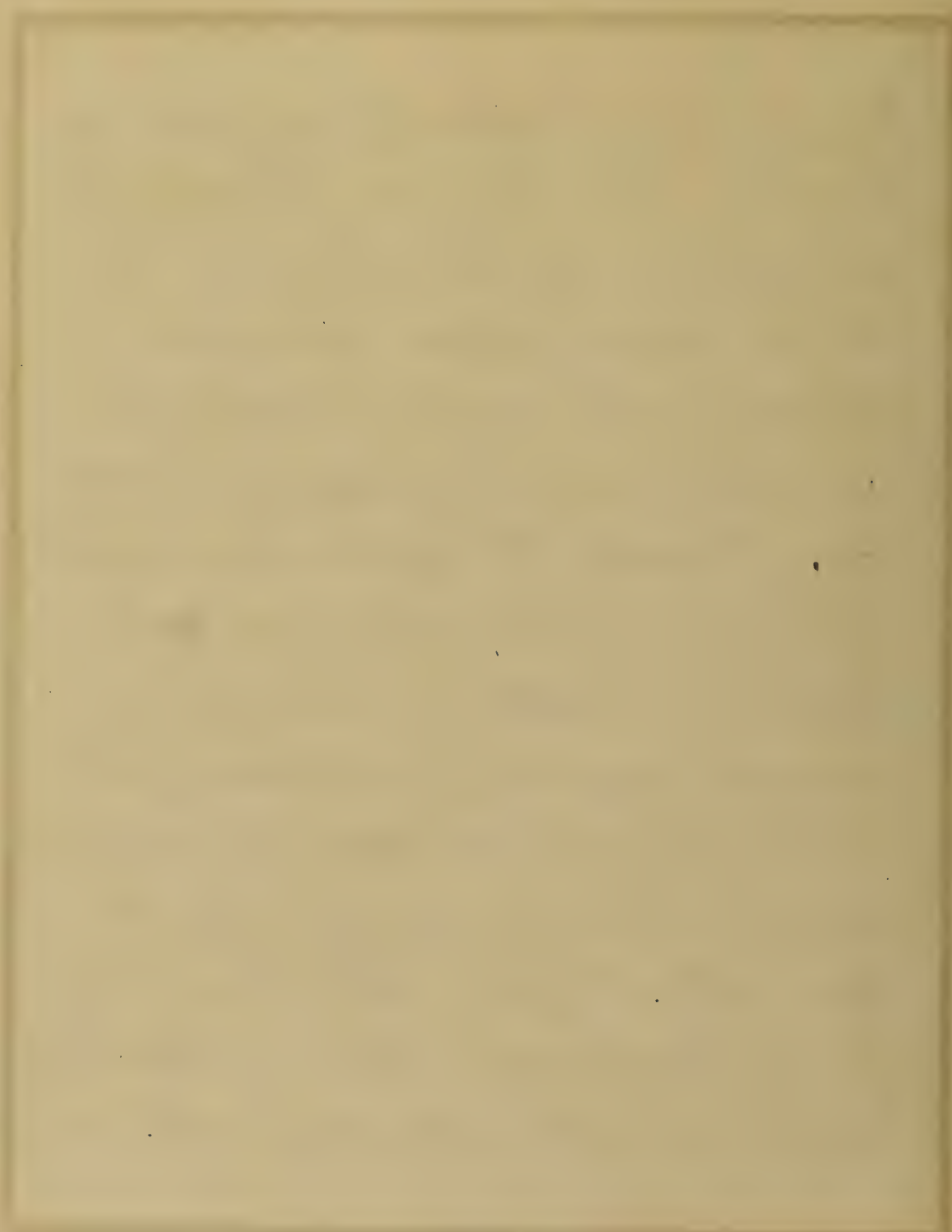


about meal times; the habit of eating meals in a hurry and rushing off to work after the meal is swallowed is very bad, the food is not well masticated but is bolted down and remains in the stomach for a long time before it is fully dissolved by the gastric juices. This is very often the cause of the heaviness felt by some people in the epigastric region so long after meals.

The tendency to indigestion seems to be inherited in some people; whether this is due to the child growing up and following the same path in life as the parent; I am unable to say.



Want of sleep predisposes to indigestion by the brain and body not obtaining the rest which is requisite; change in the weather such as excessive heat; moral depression, great sorrow. I might go on *ad infinitum* reciting causes for indigestion. Generally the first sign experienced by the party suffering from an acute attack of indigestion is violent pain in some region of the abdomen; but in the slow and insidious approach of dyspepsia there is generally no great pain felt at first, but there is a feeling of uneasiness which makes the sufferer peevish and cross and as



this feeling gradually goes on from bad to worse, if the sufferer does not obtain some relief life becomes a burden.

Very often when called to see a patient with some gastric trouble the Physician is unable to make out any definite cause for the derangement, so he sets it down under the general head of dyspepsia.

What is dyspepsia? Dr. Tanner says: "any thing which interferes with the healthy action of the stomach and intestines may give rise to dyspepsia." This seems to me to call all diseases of the digestive apparatus dyspepsia which will do well enough when we can't do better



but I hope to see the term dyspepsia
much simplified some of these days.

The stomach must have great resisting
and recuperative powers, There are several
instances on record where the most indigest-
ible things have been taken into the
stomach; One instance is that of a sailor
swallowing a number of pocket knives;
he swallowed four at his first trial,
within a few days he passed three of them,
the fourth one he never saw nor did
it cause him any inconvenience.

A few years after this when he was on
a spree with a number of comrades
he swallowed six more knives, but this



time he did not get off so easily for he was taken with vomiting and severe pain in the stomach, but he finally got rid of these also; but not content with having satisfactorily proved that he had the stomach of an ostrich he again repeated the knife eating feat and this time paid dearly for his temerity, as he became a confirmed invalid; and after lingering for some time died in a miserable condition.

At the post mortem several portions of the blades, springs, and handles were found in the stomach very much corroded. This is a very exceptional case but it



sufficiently illustrates the fact that the stomach possesses great recuperative powers. Every one has at some time in their life given their stomach a great deal more work to do than was necessary and a large number habitually overwork their stomach and by so doing lay up a store of indigestion and misery for themselves in after years.

Costiveness and constipation are not generally looked upon by unprofessional people as a disease still it is a disease and ought to be regarded as a disorder of the whole system and not of the intestinal tract alone. It is true some people



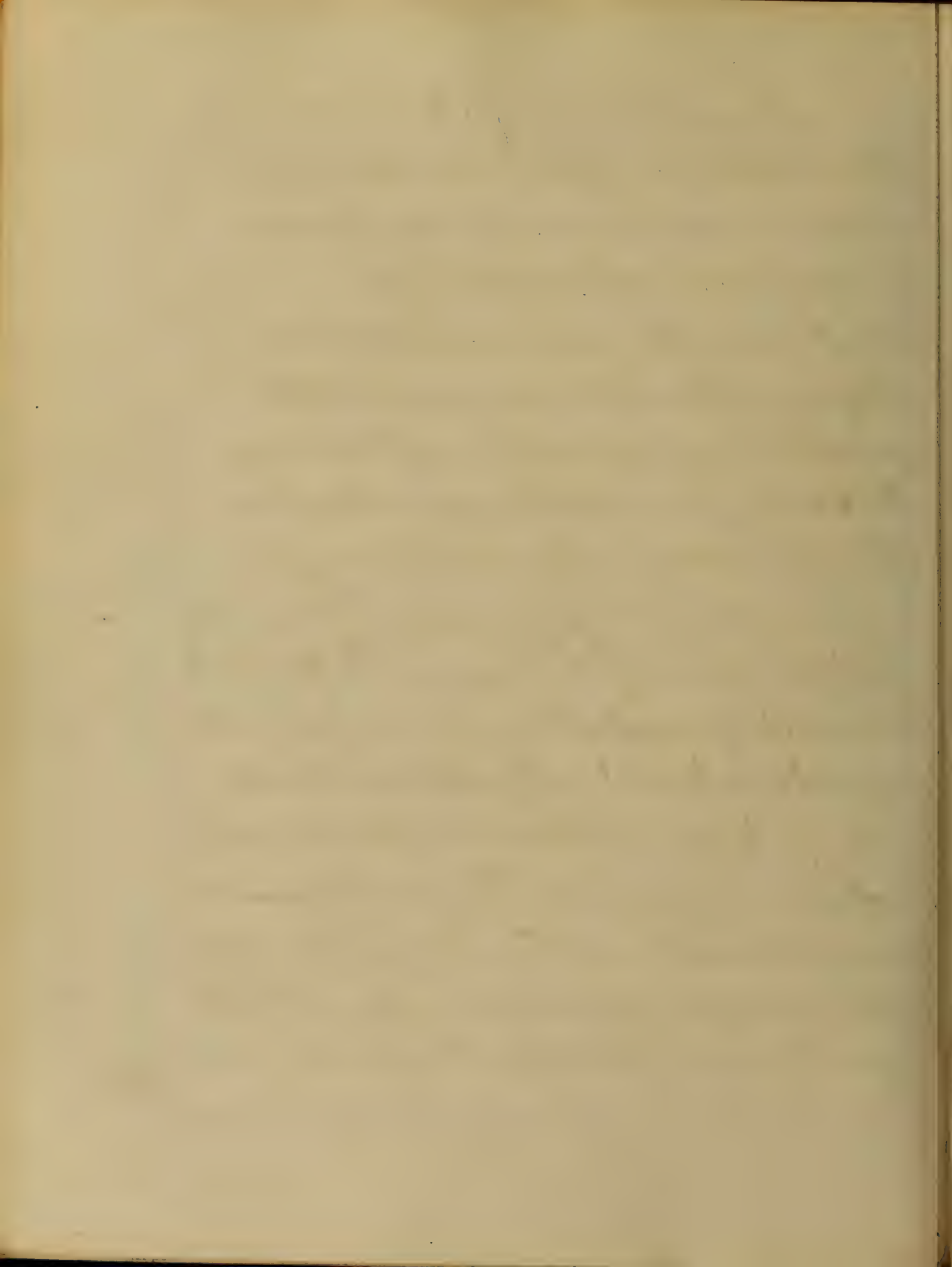
do not have an action from the bowels more than once a week and to all appearances are perfectly healthy but I can not help thinking that there is something wrong with their system. It seems natural enough that old people should not have as many actions from the bowels as people that are young and active, because there is not so much waste about their body nor do they generally consume as much food as young people.



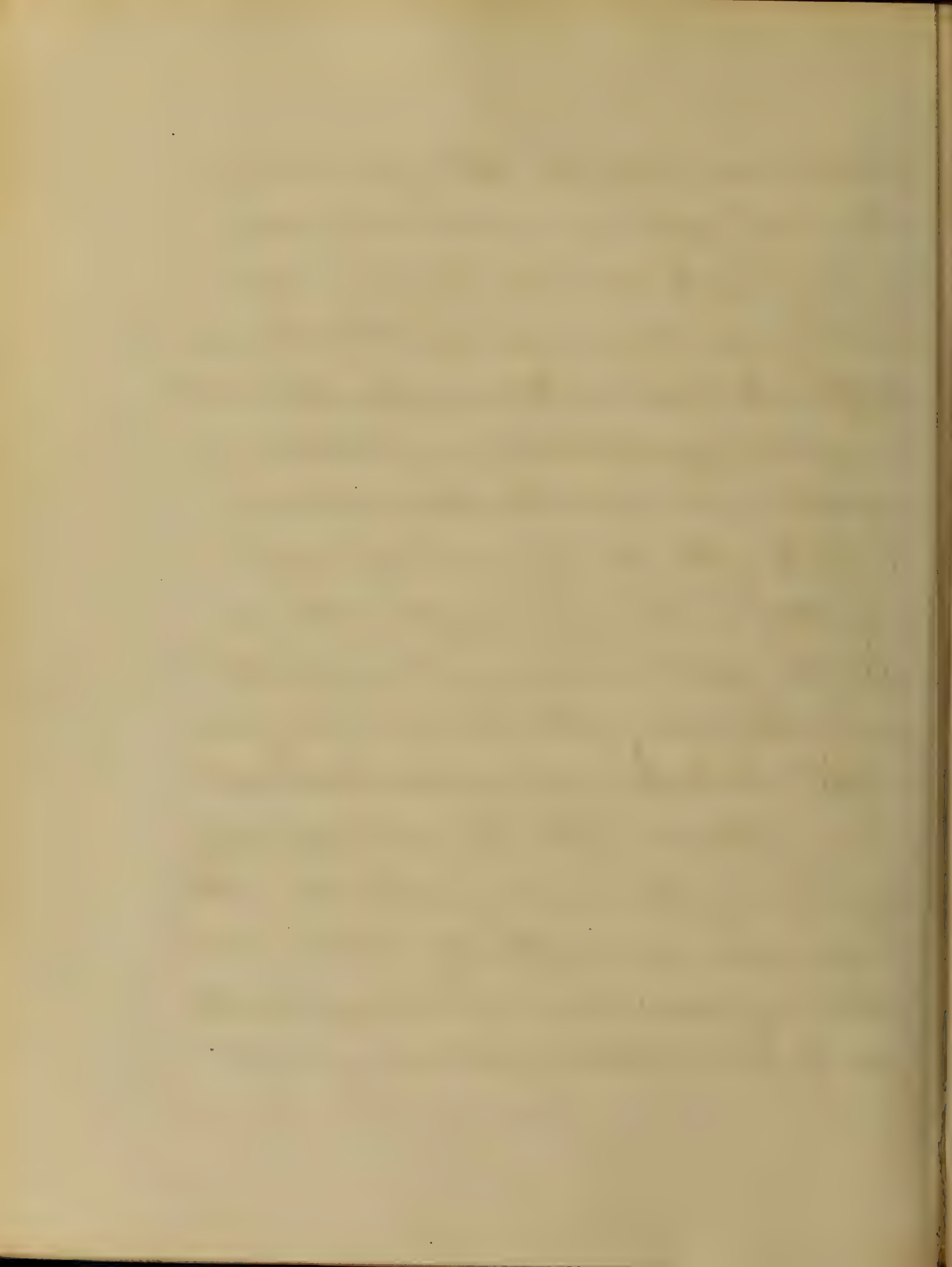
Amputation of Fore-arm

Patrick Connor - age 28 Residence City is a laborer and was admitted on Tuesday June 20th 1876 with swollen hand.

About six months previous he had been playing with a fellow-man and the latter pushed him over on his wrist bruising it severely from which a synovitis set in. This subsided to a certain extent, and upon examination it was found he had caries of all the bones of the Carpus. The treatment consisted in extension for a while until synovitis subsided, after this the hand was put up in adhesive plaster and extension applied. The joint became more diseased and it was finally amputated by Prof. C. Johnston on Nov 28th. The operation was of the flap kind making an



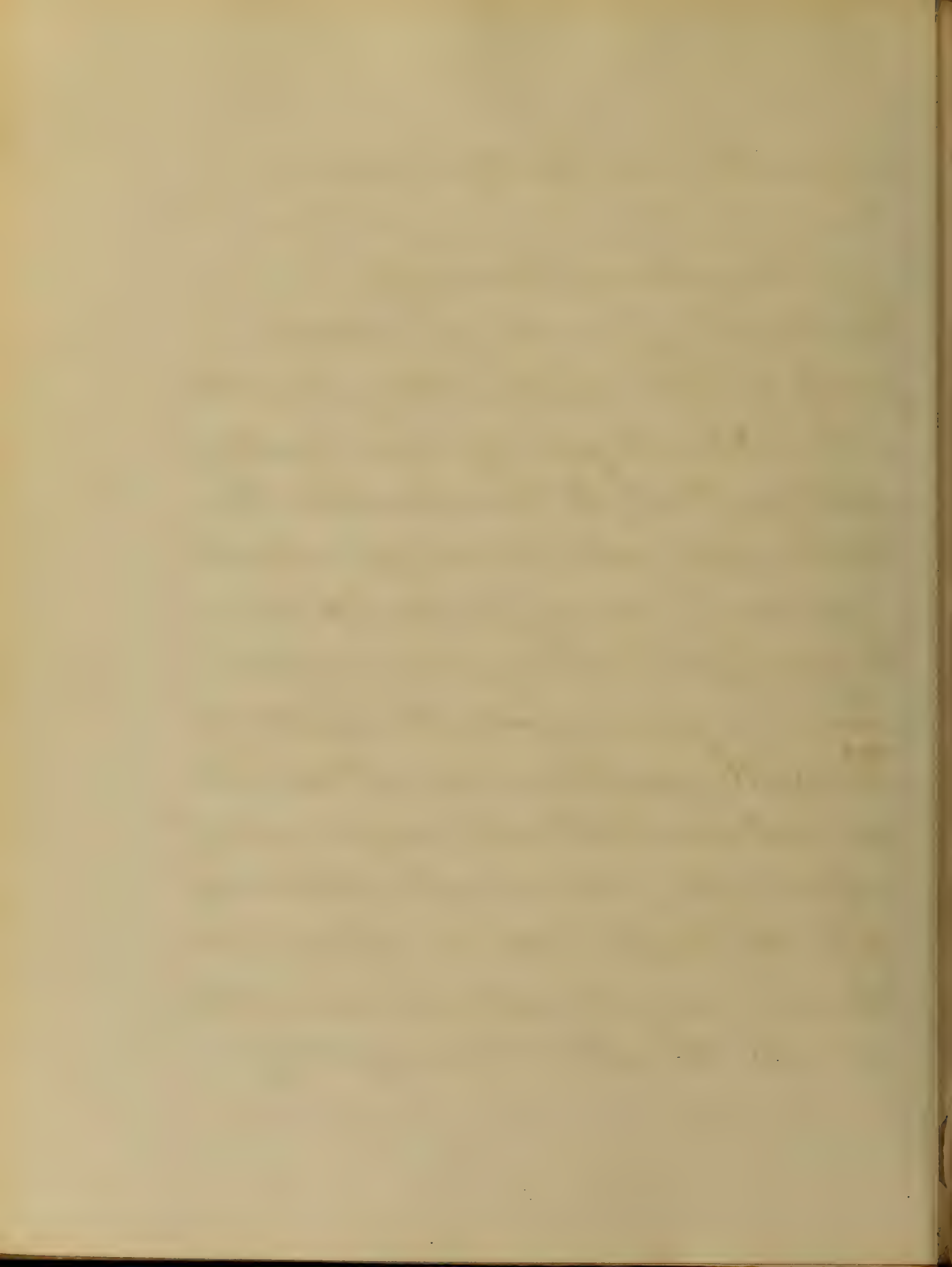
anterior and posterior. That night his temperature went up to 104 and it continued to remain up to 103 and 4 for 10 or 12 days. In the mean time signs of Phthisis developed itself and large cavities were found in both Lungs. So rapid did this complication grow that he was reduced to skin and bone in a fortnight. He was given when first admitted Tr. Ferri Chloride grs $\times \times$ ter die; after the operation was given Quinia Sulph. grs. \times bisindies, with Dover's Powder grs \times night, also took milk and towards the last was ordered Lpts. Frumenti $\frac{3}{4}$ every two hours. As he had marked Bronchitis he was given syrup of Squill & Cod-liver oil which improved him. The stump healed up by first intention, but owing to the



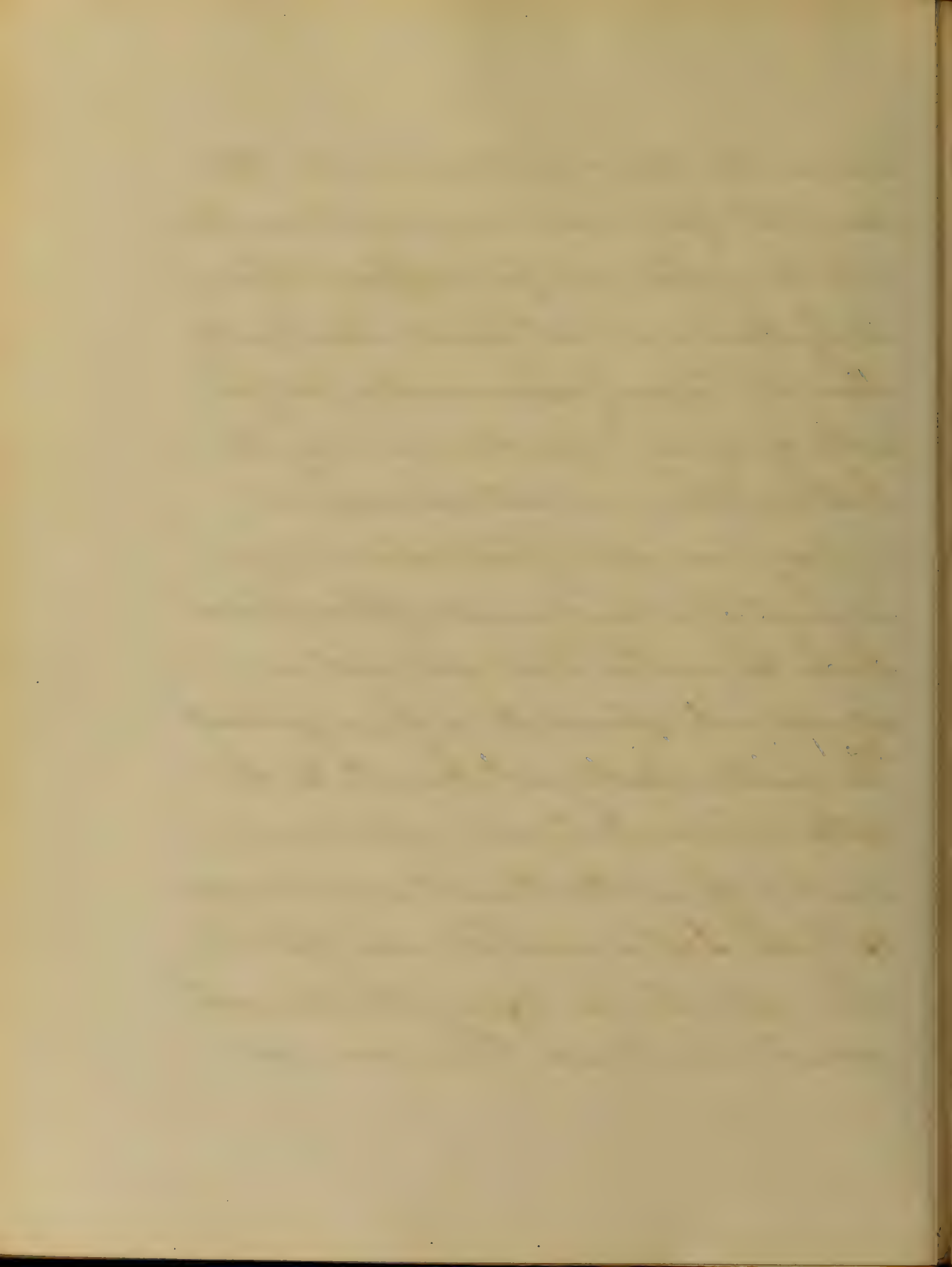
complications he finally died Dec 18.

Phosphorus Poisoning

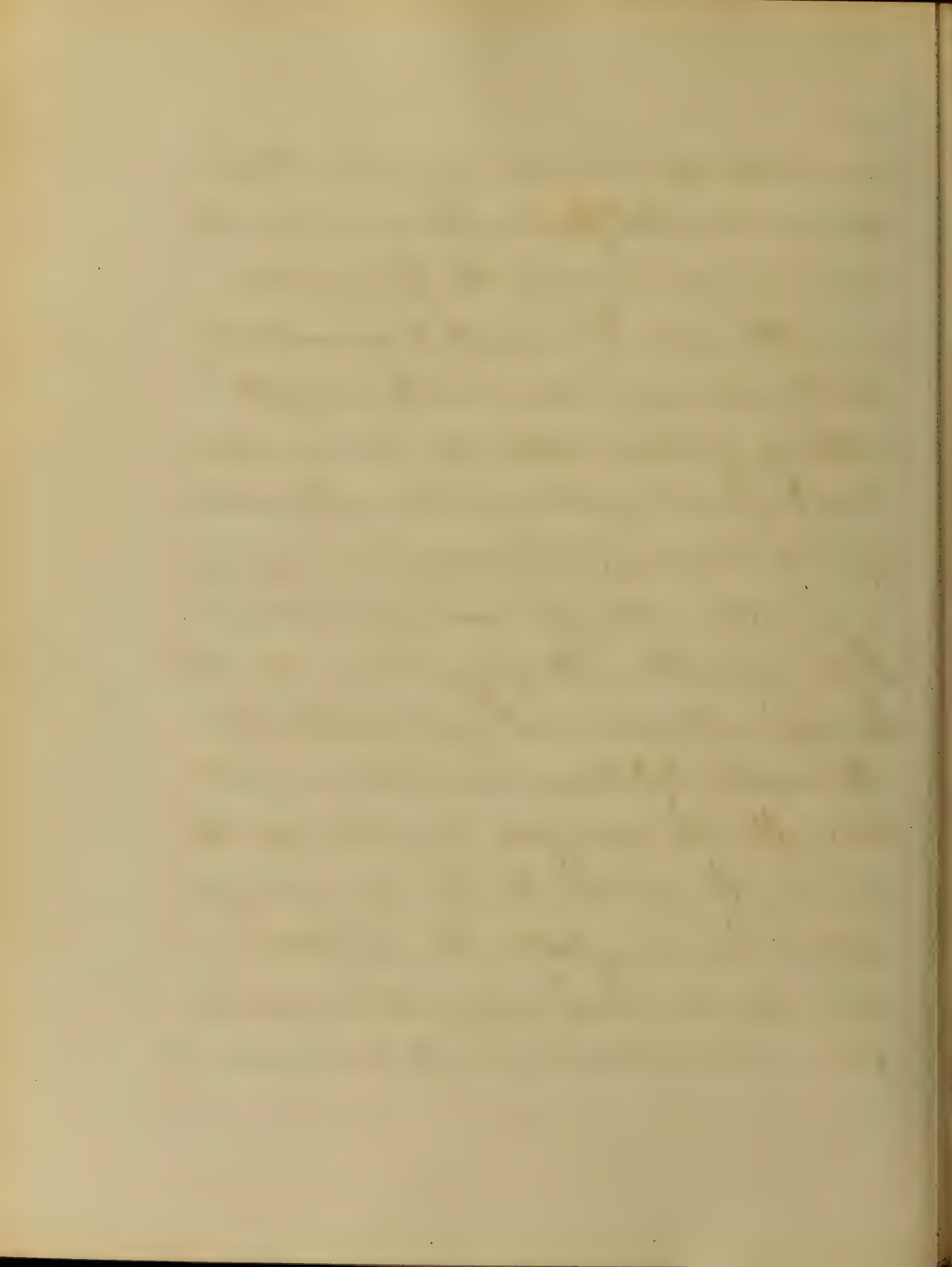
On the 20th of June I was called in great haste to see two little girls, Ruth and Letitia Snyder by name respectively residing at 287 W. Lombard St. The Mother had just returned from Market and was preparing her toilet when the youngest first began to complain. They were 4 and 7 years old respectively. The first symptoms were noticed on the youngest one, Ruth, who complained of a bitter taste in her mouth and burning of her throat and in a few minutes the other complained likewise but this was not thought to be any thing



serious. In ten or fifteen minutes after this Ruth fell over in a violent convulsion and the mother sent for 4 different Physicians all of whom were not home when finally after the lapse of an hour and a half she sent for me. I found, on arriving, the children both in convulsions and on inquiry learned they had eaten a large amount of a compound of Phosphorus which the mother had prepared in syrup and placed it in the cup-board. The children had mistaken it for the latter alone. I, at once, ordered an emetic of mustard and warm water for both. Lettia vomited once, but the other did not, she dying with the most violent convulsions I have ever seen



20 minutes after I arrived. My whole attention was now directed to the other one. I put her in a warm hip-bath for about 15 minutes, and it seemed to convert the continued convulsions into a slight twitching of the muscles. In the mean time I sent for the following. Oleum Terbinthinis ζj Pulv. Acacia ζj Aqua ζiij . Sig. ζj every 15 minutes until eight doses were taken. I also gave the white of egg at once to soothe the inflamed and cauterized coats of the stomach but to no avail. In a short time after the removal from the hip-bath she sank into the terrific spasms again and I then resorted to the inhalation of Chloroform which allayed the spasms for a while, but she finally died 45 minutes



after I had entered the house.

Their mouths were cauterized from the caustic action of the poison. The older of the two vomited large shreds of mucous membrane which either came from the mouth or stomach. The symptoms appeared in these cases about an hour after taking the fatal dose.

Fracture of the Thigh

F. W. age 28 a seaman, fell on the ice while walking to the Ship and on rising to the ground, found he could not walk, but did not experience any pain. He crawled to the Ship on his hands and abdomen that night and the next day December 25th was brought to the Hospital. After a little examination he was found



to have a fracture of the right femur in the upper part of the middle third. There ~~was~~ great deformity, crepitus and inability to stand, along with pain on every movement of the limb.

The limb was put in N. B. Smith's anterior Splint and extension applied. The treatment consisted in this alone and perfect quiescence for six weeks.

He is now, seven weeks latter, walking about the Ward with one crutch and the limb is only one half an inch shorter than his other one. He complains of a little stiffness about the knee joint, otherwise he is perfectly well. His general condition has not been impaired at any time.



Acute Tubal Nephritis

G. R. age 32 was admitted into the Hospital on Oct 31st 1876 with severe chills & fever. He complained of great pain in the loins and in examining the urine it was found to be heavily loaded with albumen. He was at once ordered Quinia Sulph. grs x v, his feet and abdomen but most markedly his face right under the eyes were oedematous and swollen, his pulse was 124 and respirations very rapid. Next day he was not better and was ordered Potass. Bitartrate zj Pulv. Cubebæ zj Aqua Oj Sig to be taken as a drink in molasses, also was ordered Spts Aetheris Nitrosi zij Syrupus Scillae zss Tr. Ferri Chloride zij Sig zj ter die.

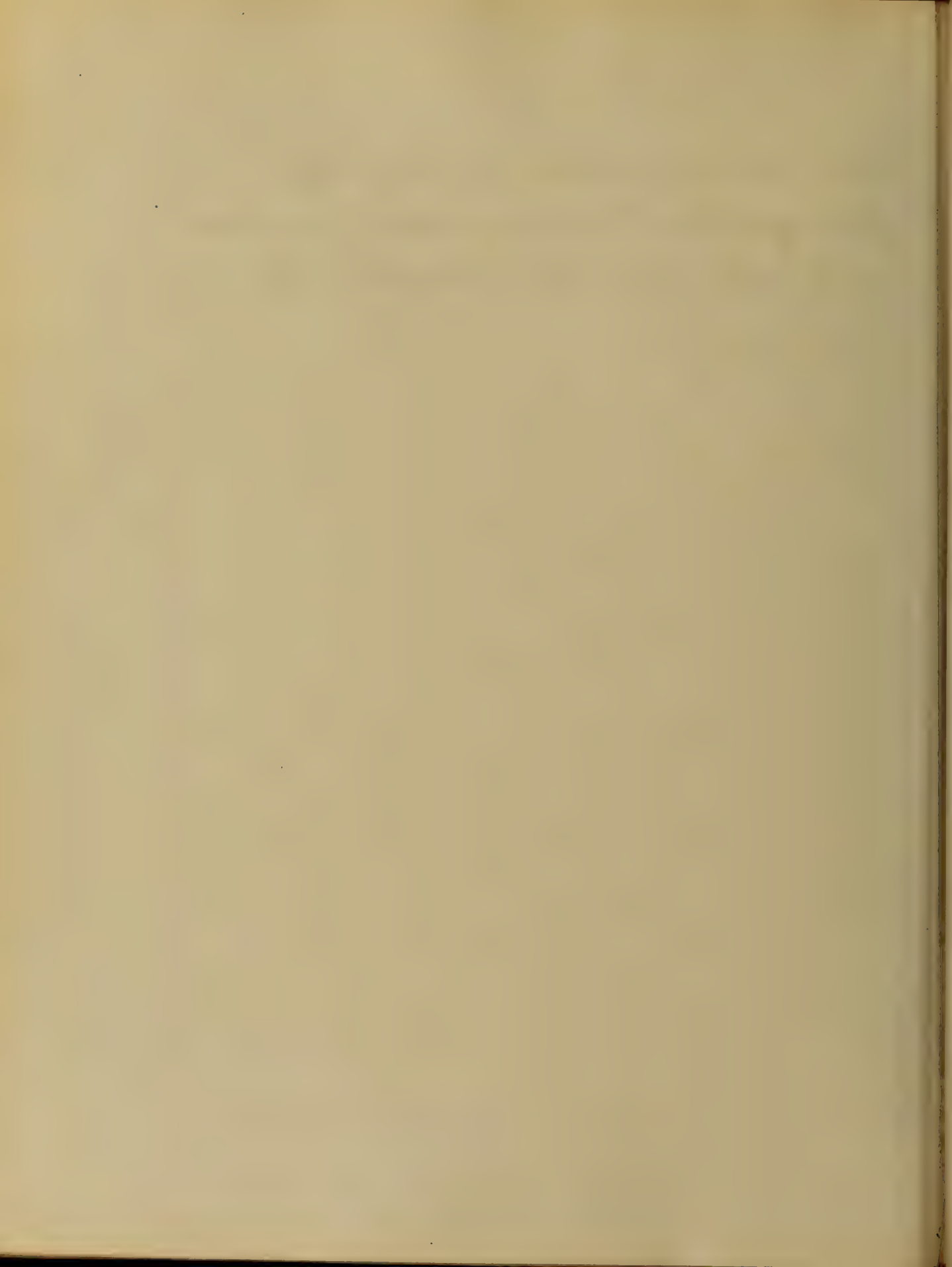


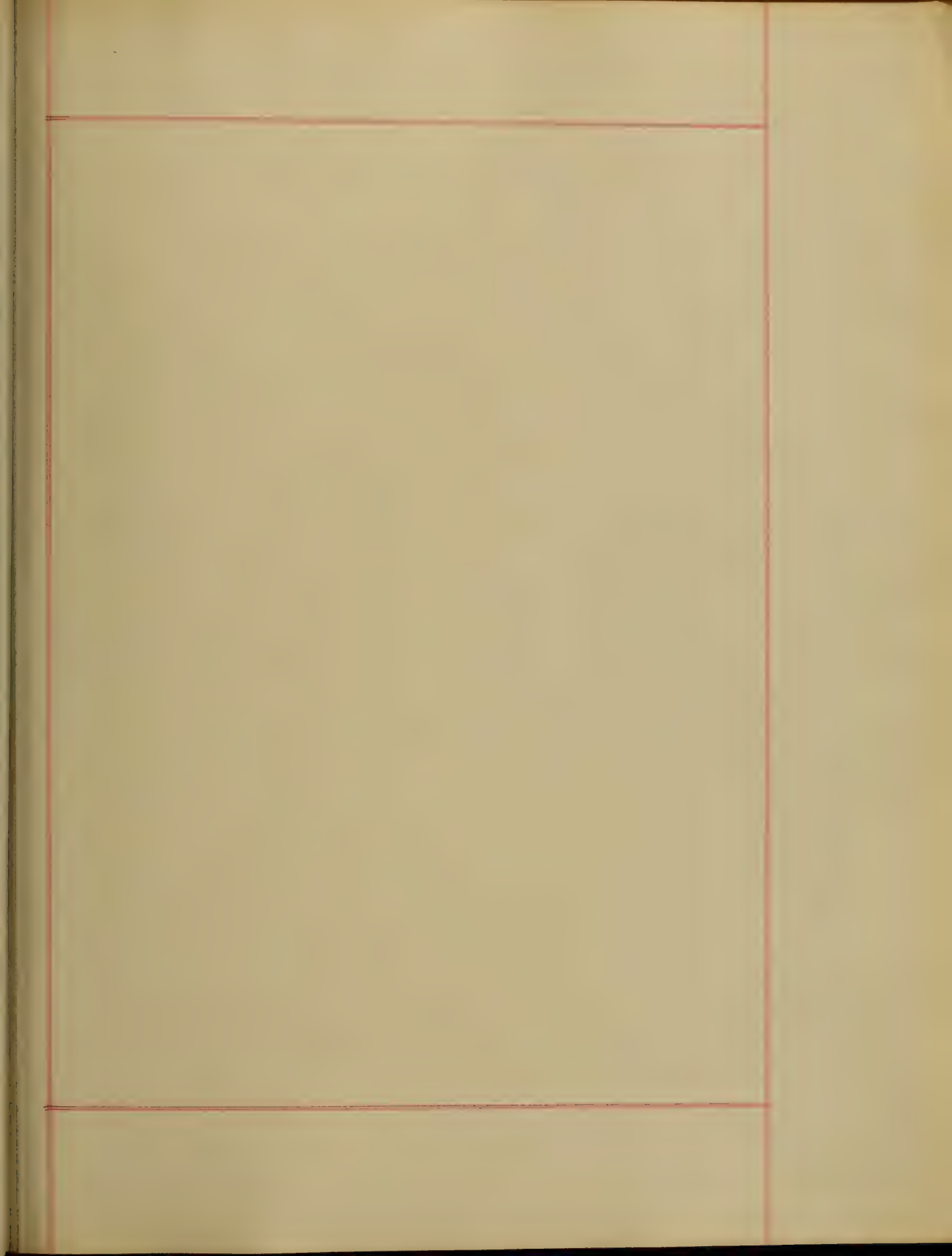
Under this treatment he improved rapidly, the swelling in his face decreased first, he was kept in bed and continued to take this treatment.

His urine was examined from time to time with heat and nitric acid, and the presence of albumen gradually diminished. It was also examined by the microscope and epithelial casts were found in abundance. He had been subjected to working in the water and was compelled to sleep in his wet cloths, he had also been suffering with intermittent fever for six weeks before. He was ordered House Tonic and his urine was examined this day Feb 13th and the epithelial casts

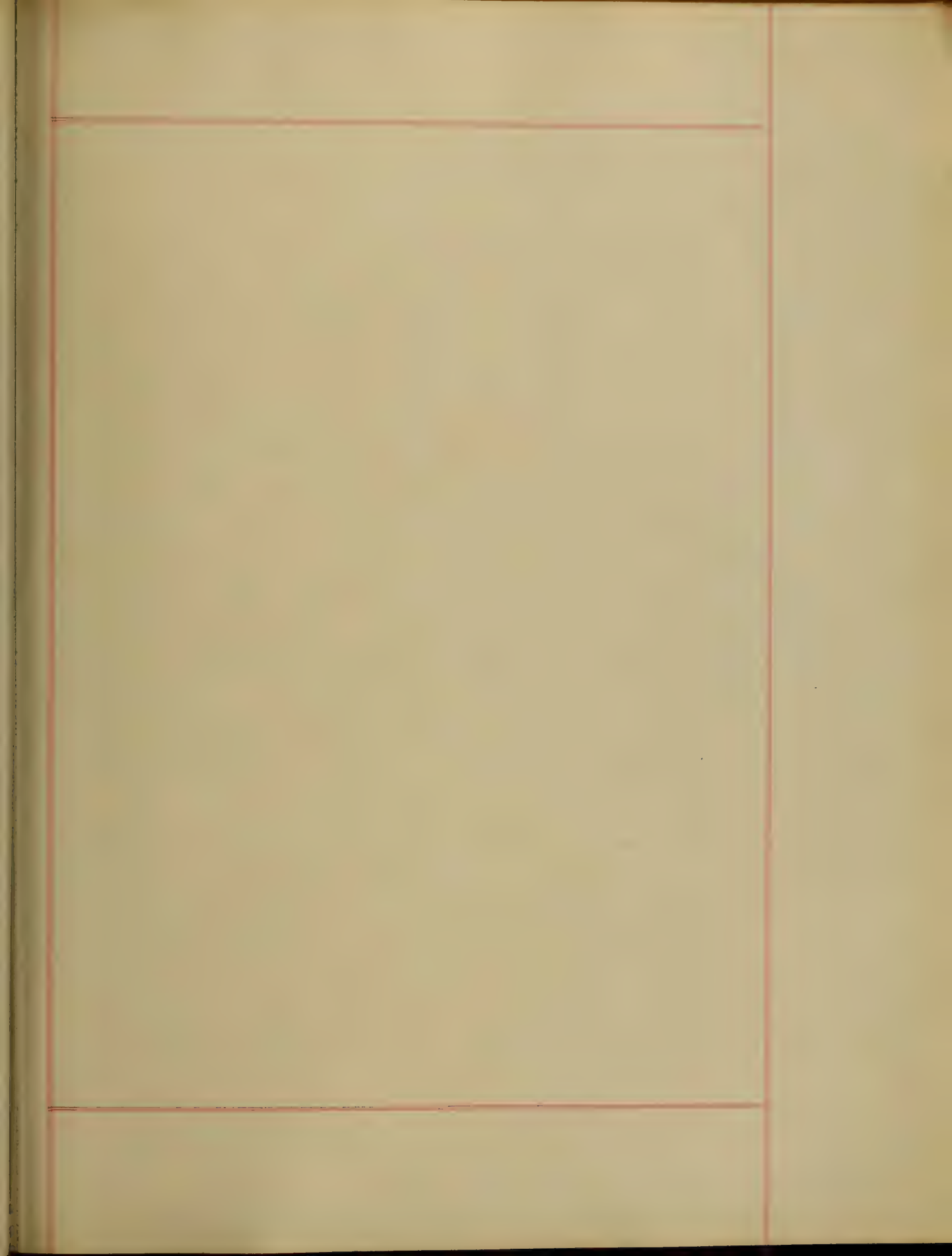


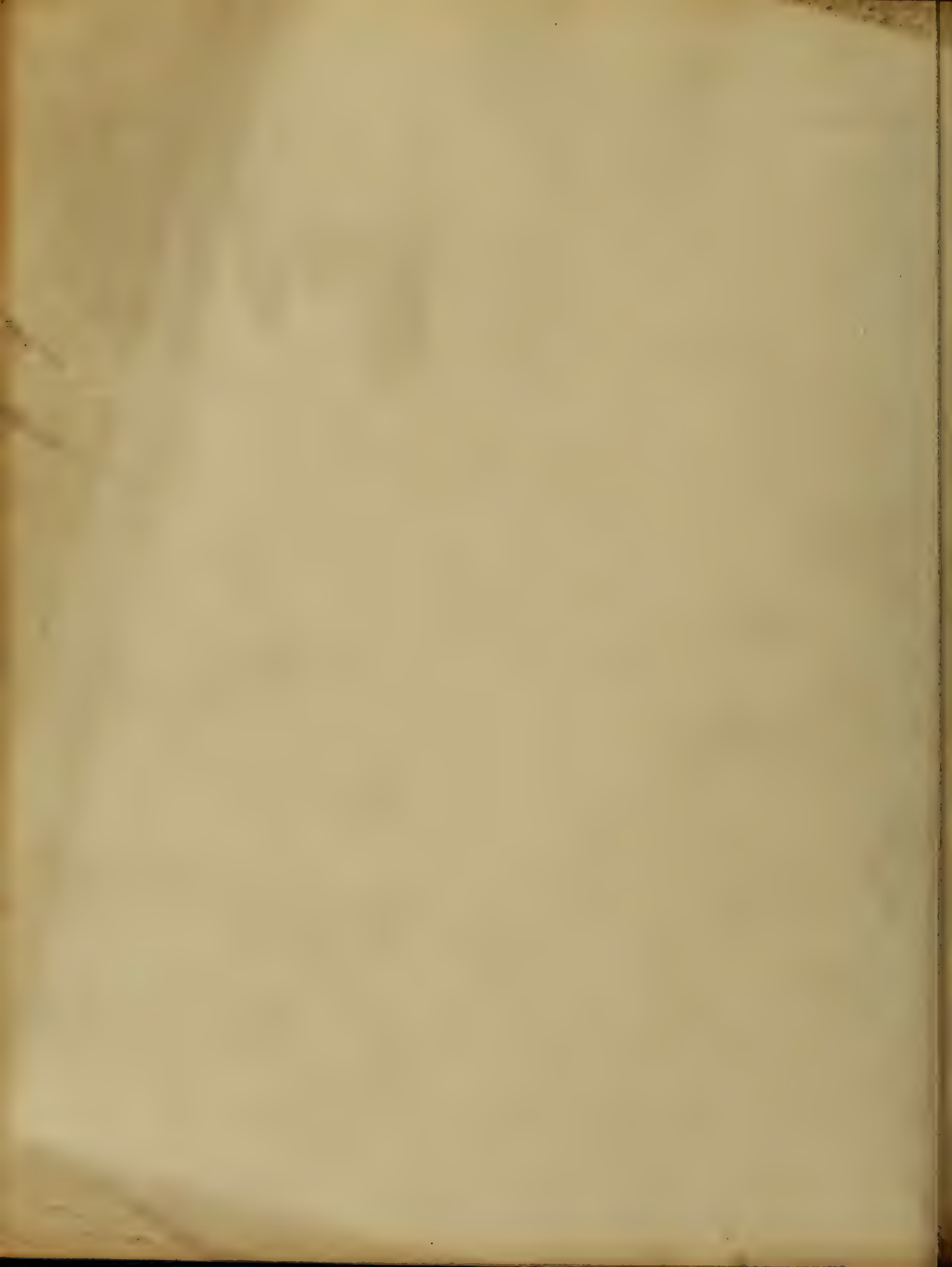
were few in number and hardly perceptible. He has gradually improved and will leave the Hospital this week.











Thesis on
Acute Croupal Pneumonitis
by
B. Frank Whiteside -
Class 76 - 77

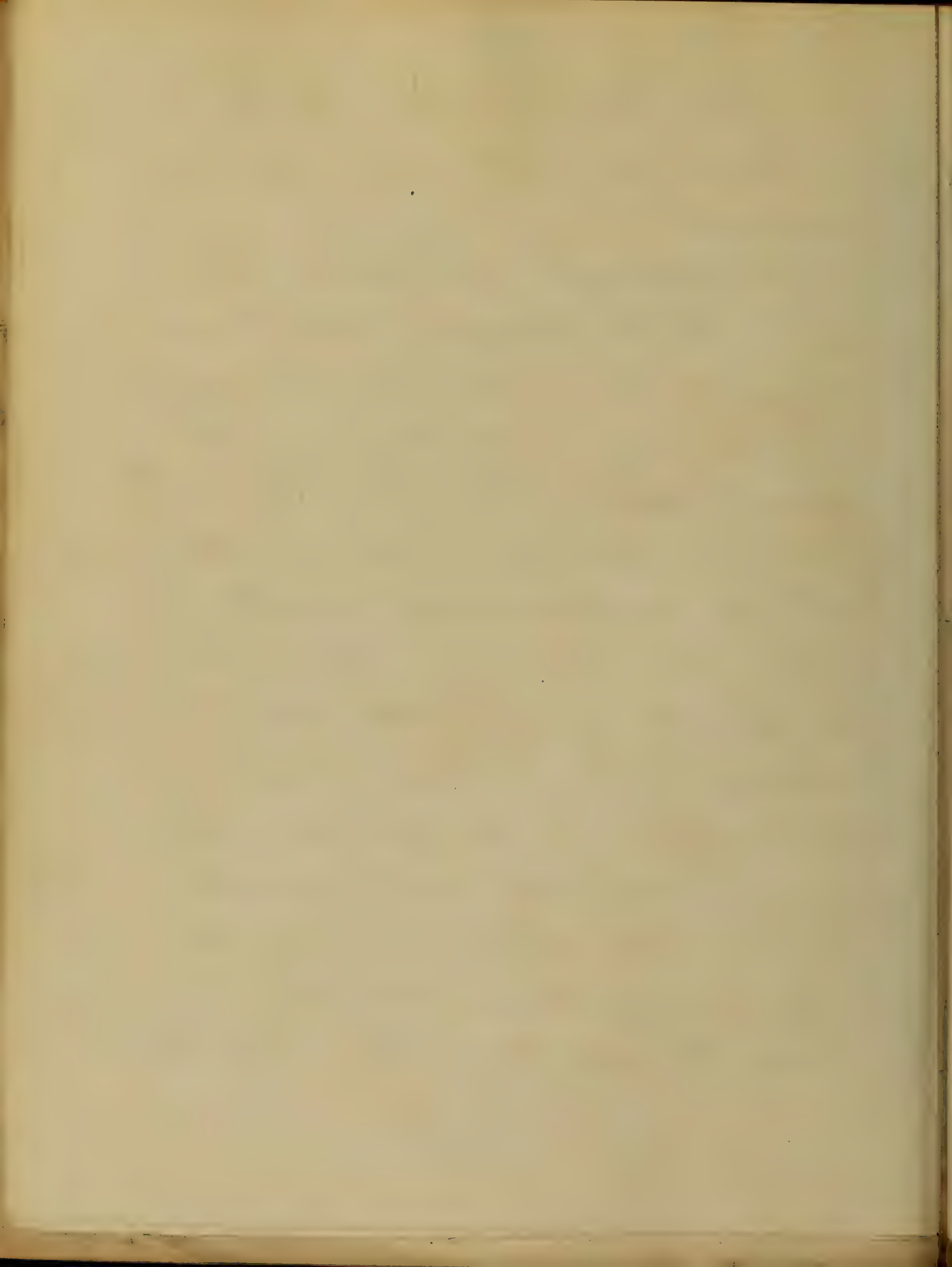


Acute Bronchial Pneumonitis

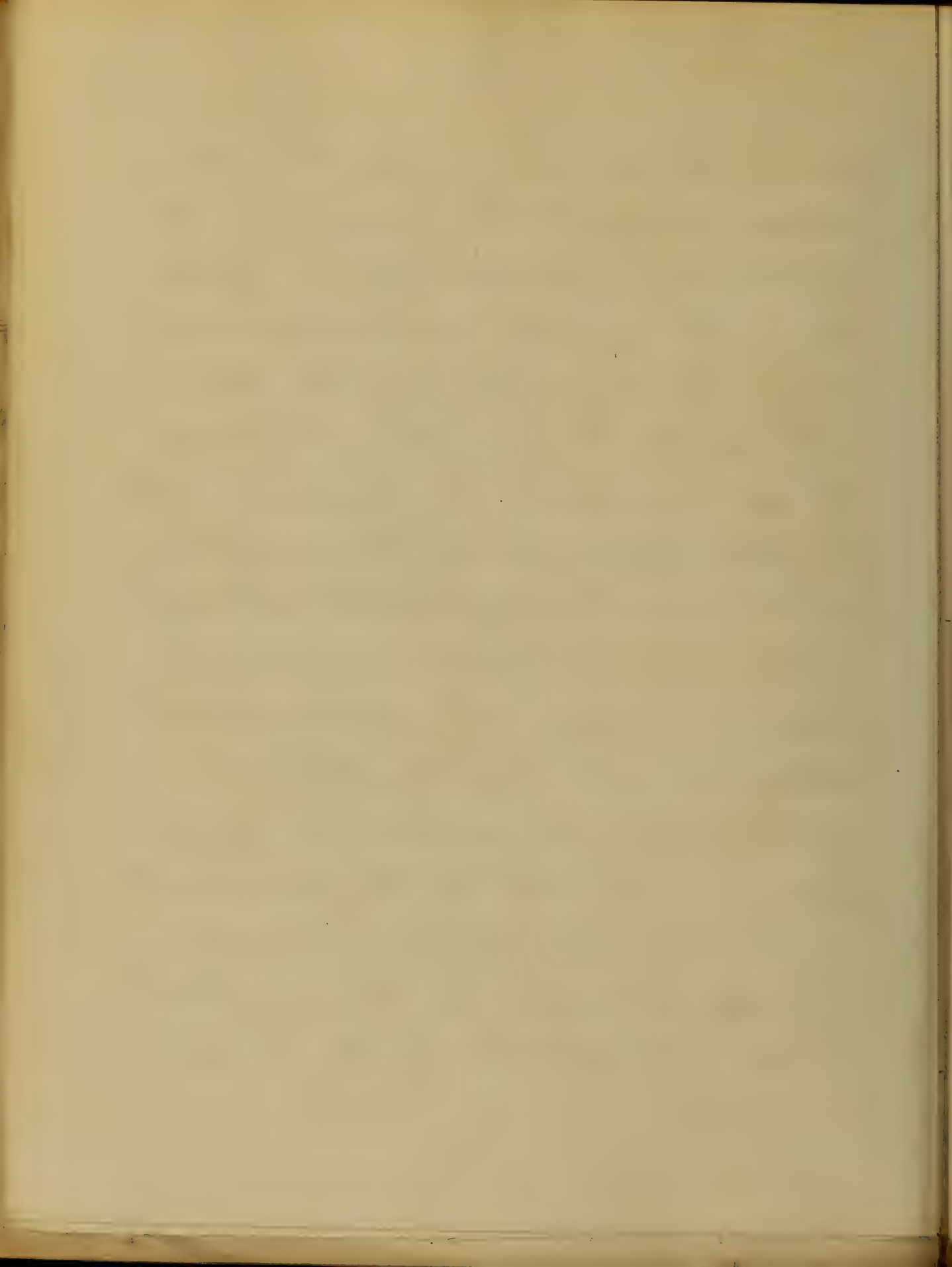
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Definition. Inflammation of lung substance.

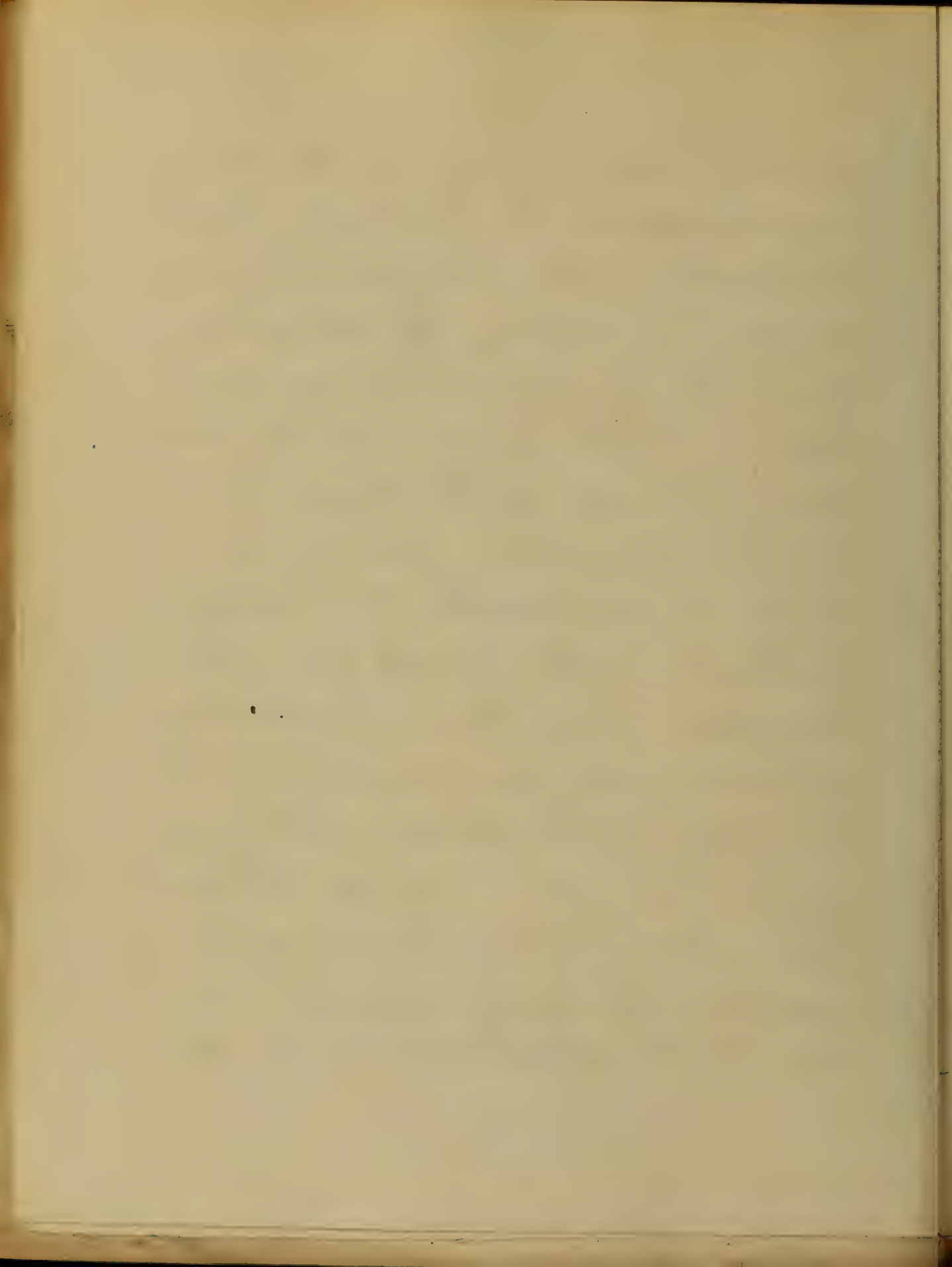
Anatomical characters. The first noticeable change is that of engorgement, due to an increased quantity of blood in the organ, which gives it additional weight. Externally it is of a dark, red color, slightly pits on pressure, and crepitates less than when normal. On section, a quantity of red frothy serum is observed to flow. This hyperaemia does not prevent the air from entering the air sacs, and from the first a little albuminous liquid is effused into them. A portion of lung thrown in water will still



float; but exudation speedily follows, which indicates the commencement of second stage - that of red hepatisation. The exuded matter soon coagulates, greatly distending the air cells, and thus preventing the passage of air inwards. The increased weight in this stage, is due to the exudation, which consists of epithelial cells, and solid material withdrawn from the blood. Its spongy character and crepitation is lost; it will not float in water. A cut surface has an appearance like that of the liver, and a quantity of frothy fluid can be pressed out, but less than in first stage. The substance of the lung is

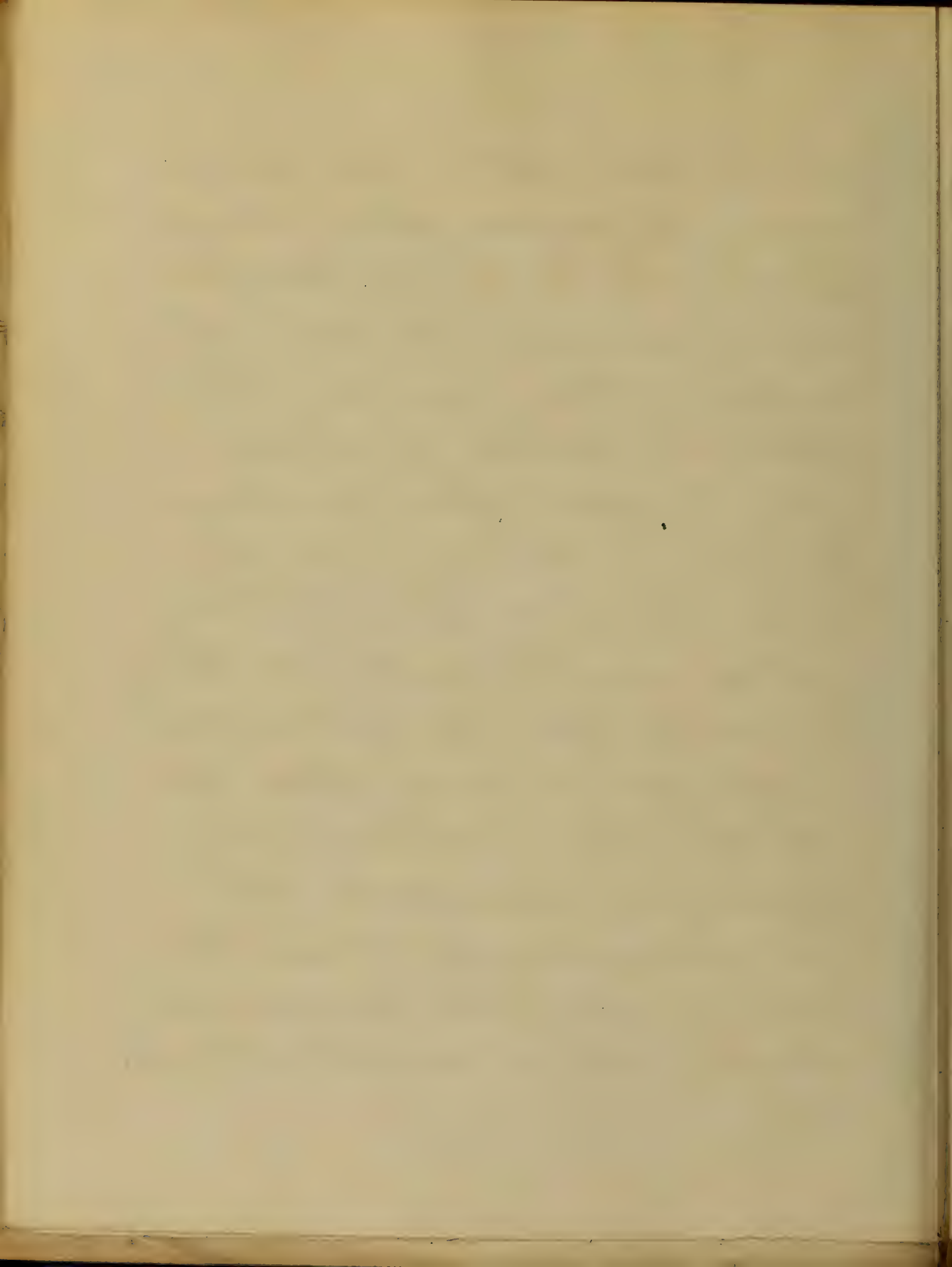


softened and readily breaks down under pressure. If the disease pursue a favorable course, the exudation is removed principally by absorption and in some cases with great rapidity. After its removal the functional capacity of the organ seems to be fully restored. But if the course be unfavorable, the morbid material is not removed from the air sacs, and there is infiltration of fibrine and pus, constituting the third stage of the disease - that of gray hepatization. The lung is still impervious to air; it is more friable, and can be easily reduced to a pulp by the slightest pressure. On



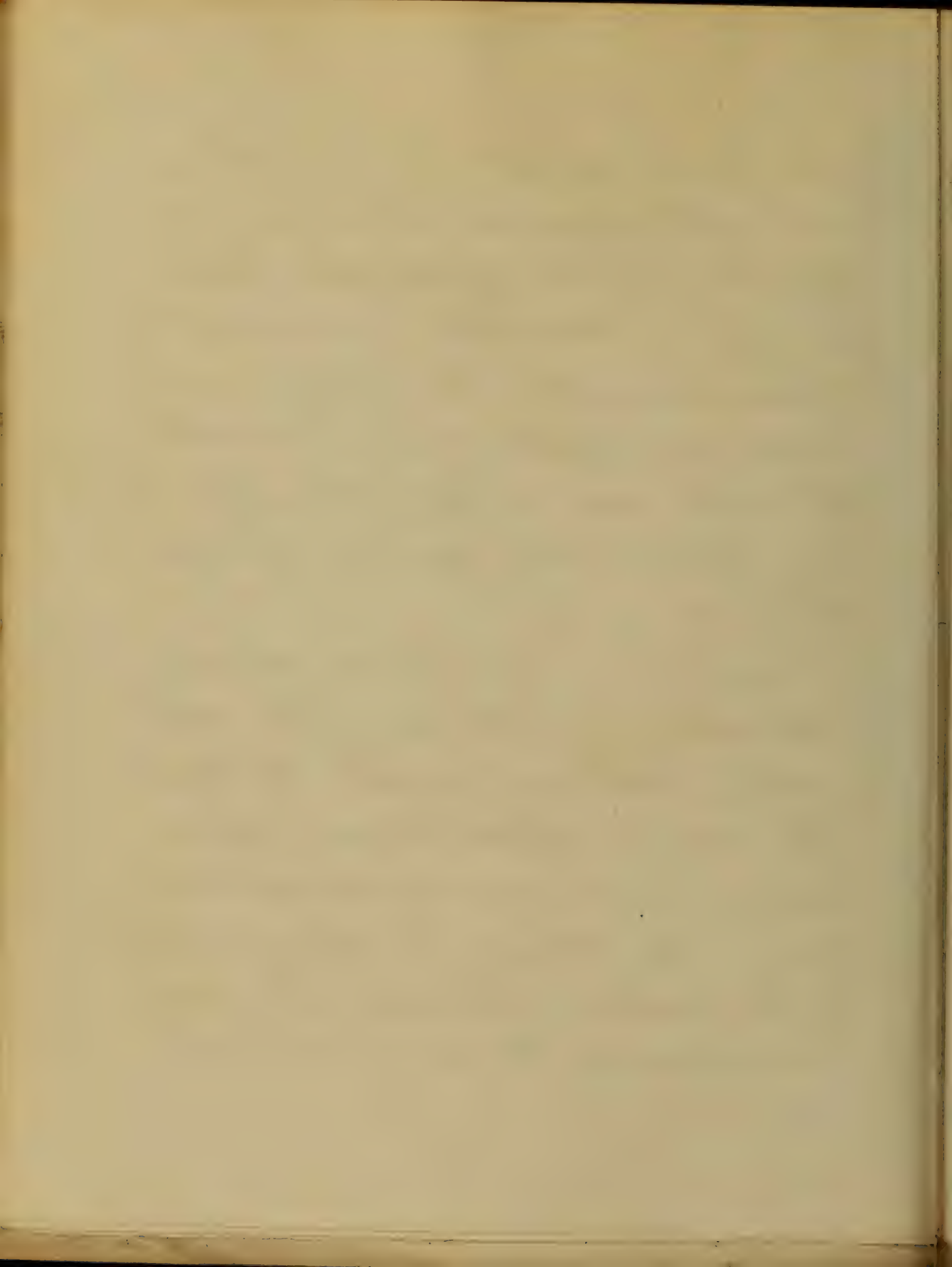
sections, there will be an abundant oozing of puriform matter. Sometimes a collection of pus takes place forming abscesses; but acute inflammations of this organ, are not so liable to be followed by abscess, as when it affects other parenchymatous tissues. Gangrene sometimes result, but it is extremely ^{rare}. A large portion may be involved, or it may be more limited. The part involved is of a greenish brown color; of a soft consistence; emitting a very offensive and characteristic odor.

In a large majority of cases there exists a more or less circumscribed pleuritis, with an exudation of lymph.



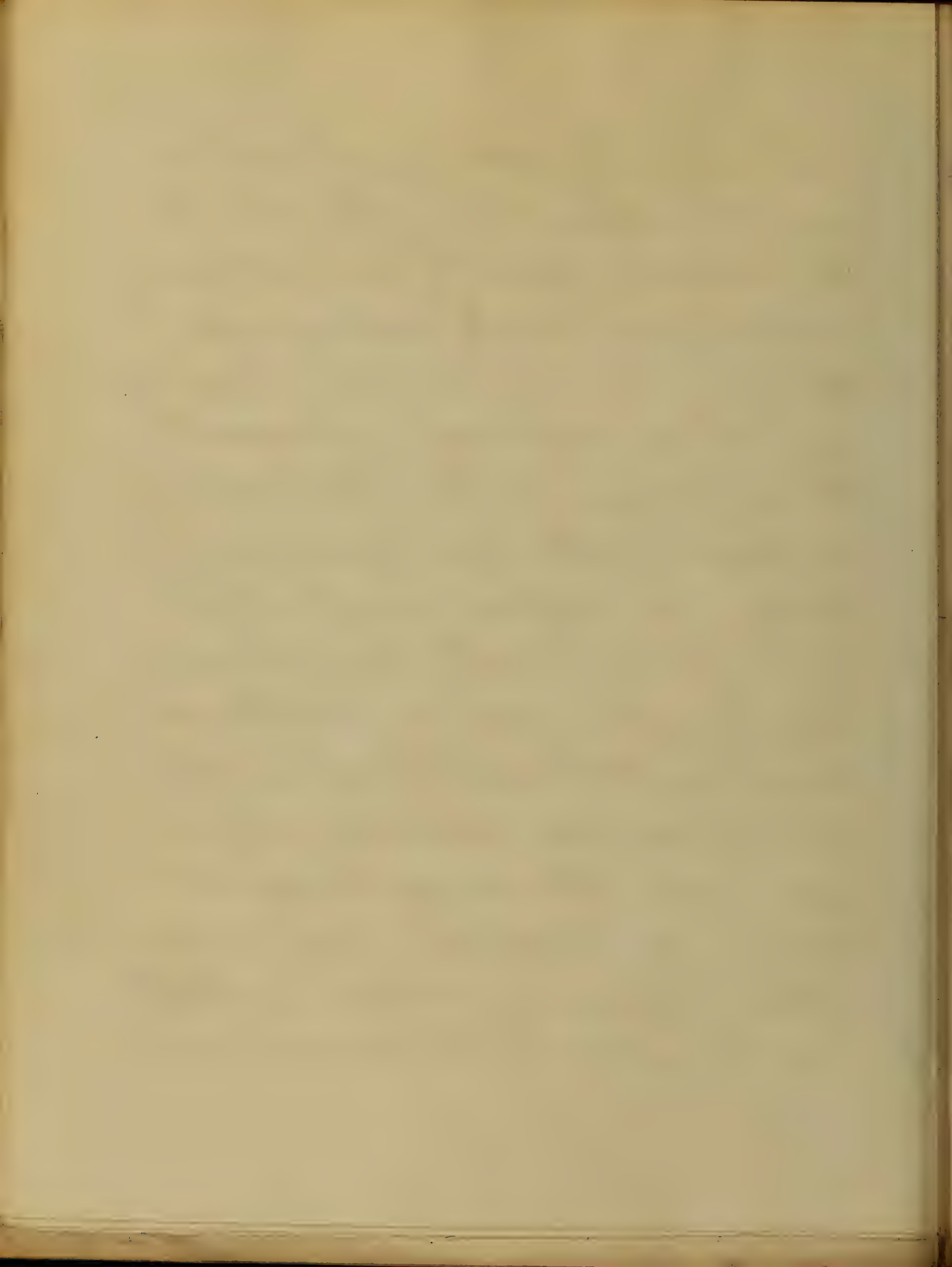
The pleuritis is apt to be dry; still we meet with cases in which there is a quantity of fluid effused into the pleural sac. Bronchitis is a constant accompaniment. The lining membrane is congested, swollen and softened; and more or less of the inflammatory products are found in the affected tubes.

Symptoms. Pain, fever, generally preceded by chilliness, pulse accelerated, breathing hurried and oppressed, cough, expectoration, headache, and in some cases nausea and vomiting. The pain in this disease is due to the coexisting pleuritis, and may be experienced at any portion of the



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chest; but its most frequent seat is near the nipple. It is most severe at the beginning, gradually diminishing in intensity, and finally ceasing before the disease has run its course. Pressure, and all acts requiring a movement of the chest, aggravate it. The decubitus is dorsal, to allow free expansion of the lungs. The dyspnea may be slight or intense. It is mostly due to the existing bronchitis, and is generally in proportion to the extent and severity of the inflammation. Delirium occurs in some cases. The cough, though not peculiar, is at first dry, and is soon followed by an expectoration of a slightly viscid mucous, which becomes more

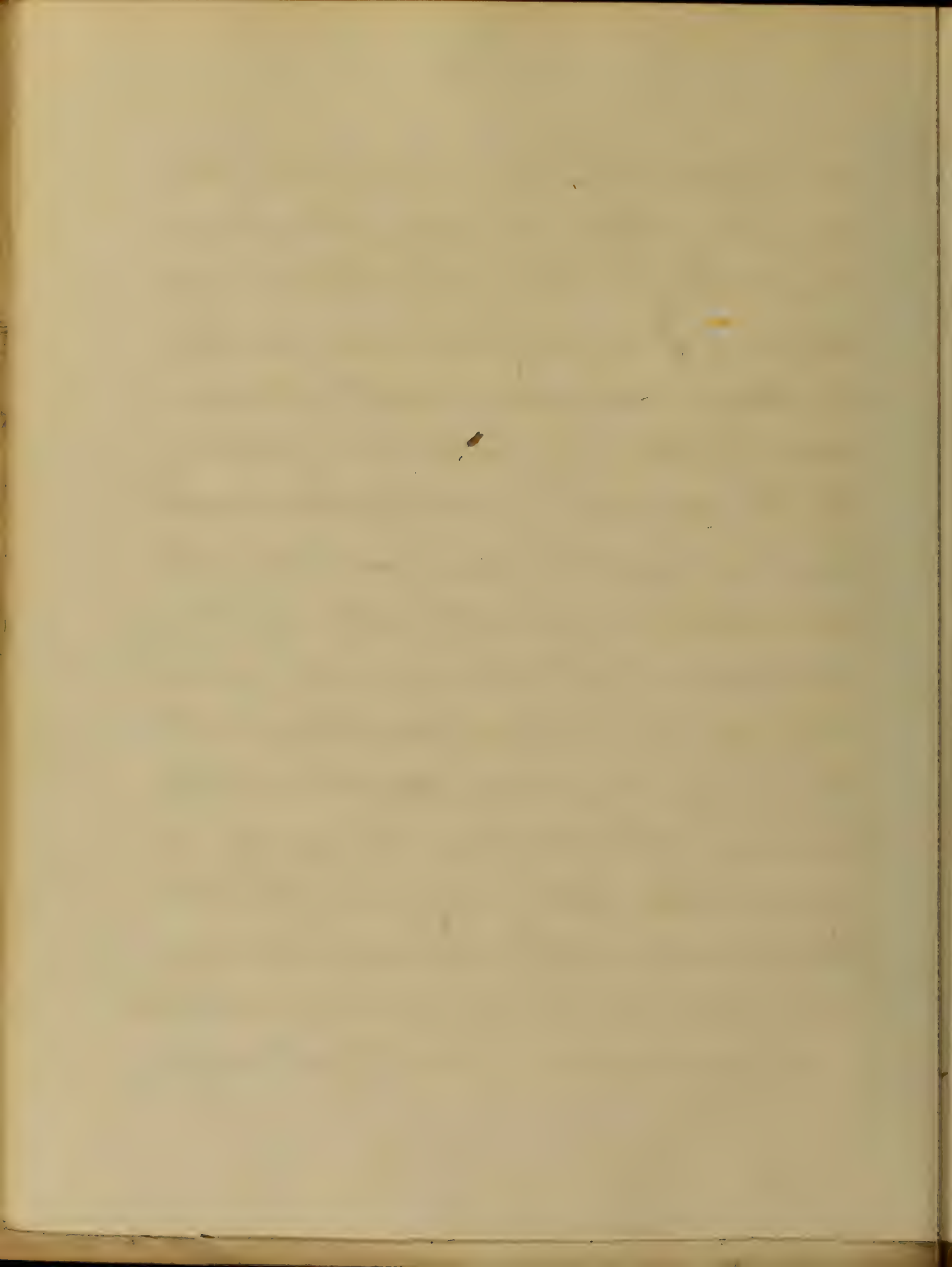


abundant, and of a rust color about second or third day, from the admix-
ture of blood. It is characteristic of the
disease. It is very tenacious and if
the disease progress favorably, it soon
loses its tenacity and tawny color.

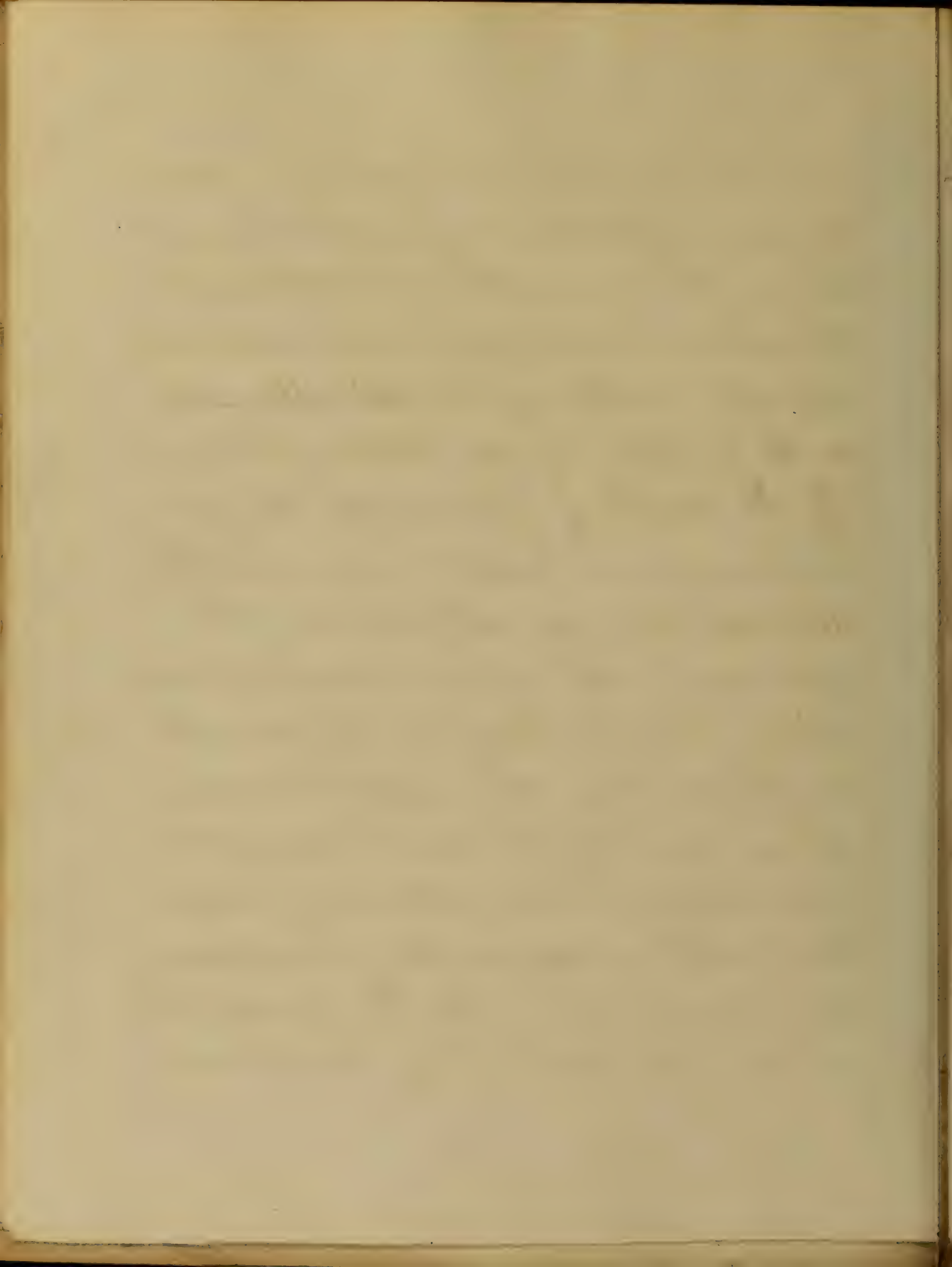
If the advance be not towards resolu-
tion, we have the primum facie expectora-
tion, which is an unfavorable symptom.

The amount of fibrine is greatly increased.
It is found in larger quantities in this
than any other disease, except acute rheu-
matism. The secretions are scanty. On
examination of the urine we find it to
be deficient in the chlorides, which reap-
pear upon the removal of the exudation.

Physical signs. In the first stage, we



have slight dulness on percussion, and the fine crepitant rale, as revealed by auscultation. It is usually a moist sound, though said to be dry, and is due to the separation of the agglutinated cells walls, or the bursting of air bubbles in the liquid. If this crackling predominates, the vesicular murmur is hushed; and when the dulness becomes well marked, this gives way, and we have Bronchial respiration, Bronchophony, and increased vocal fremitus. This marks the second stage, and if it now terminates by resolution, we have returning crepitation, which is coarser than in advancing pneumonia. If the disease advance to the third stage, the dulness is

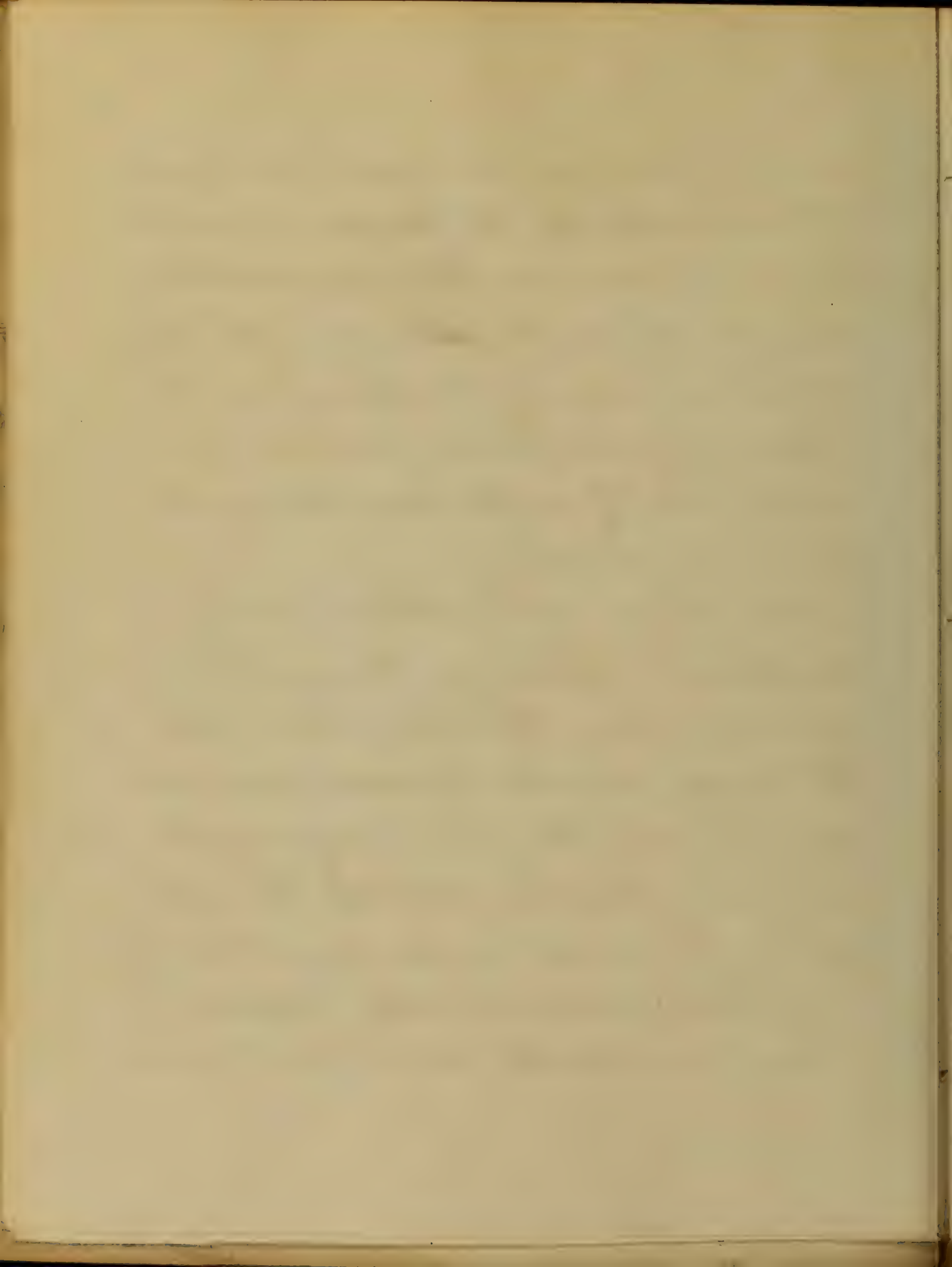


marked, and we have coarse mucous rales.
The duration of the disease is variable.
In some cases convalescence is established as early as the sixth or eighth days, others are more protracted. In most cases only one lobe is involved; the lower lobe of right lung being its most frequent seat.

Causation. Cold, either partially or suddenly applied, is the most frequent cause. Statistics show that the larger number of cases occur during the winter, and spring months.

It may also be produced traumatically. It comes on in some cases of eruptive fevers, especially typhoid.

Cases are reported in which it came

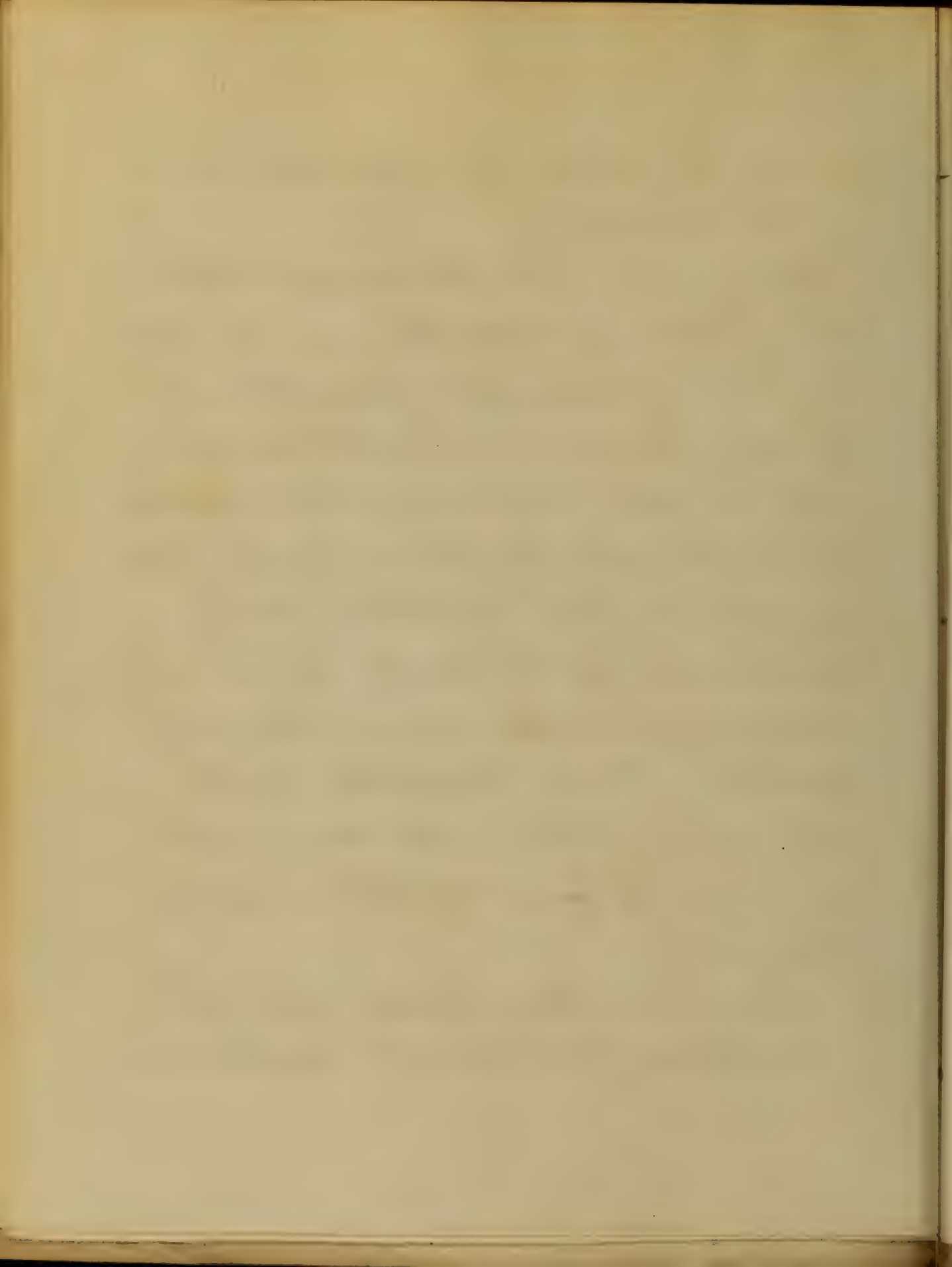


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or in the course of degenerative disease of the kidneys.

Diagnosis. This disease is liable to be mistaken for pleuritis and Bronchitis, but by a correct appreciation of the symptoms and physical signs, we will be able to clear up the diagnosis. From pleuritis, by absence of sharp pain in side, by fine crepitations, rusty sputa, and by the line of dulness remaining the same upon a change of position. From Bronchitis, by the absence of rales and sonorous rhoncus, and by fine crepitation, rusty sputa, &c.

Prognosis. This depends upon the condition of the patient, complications

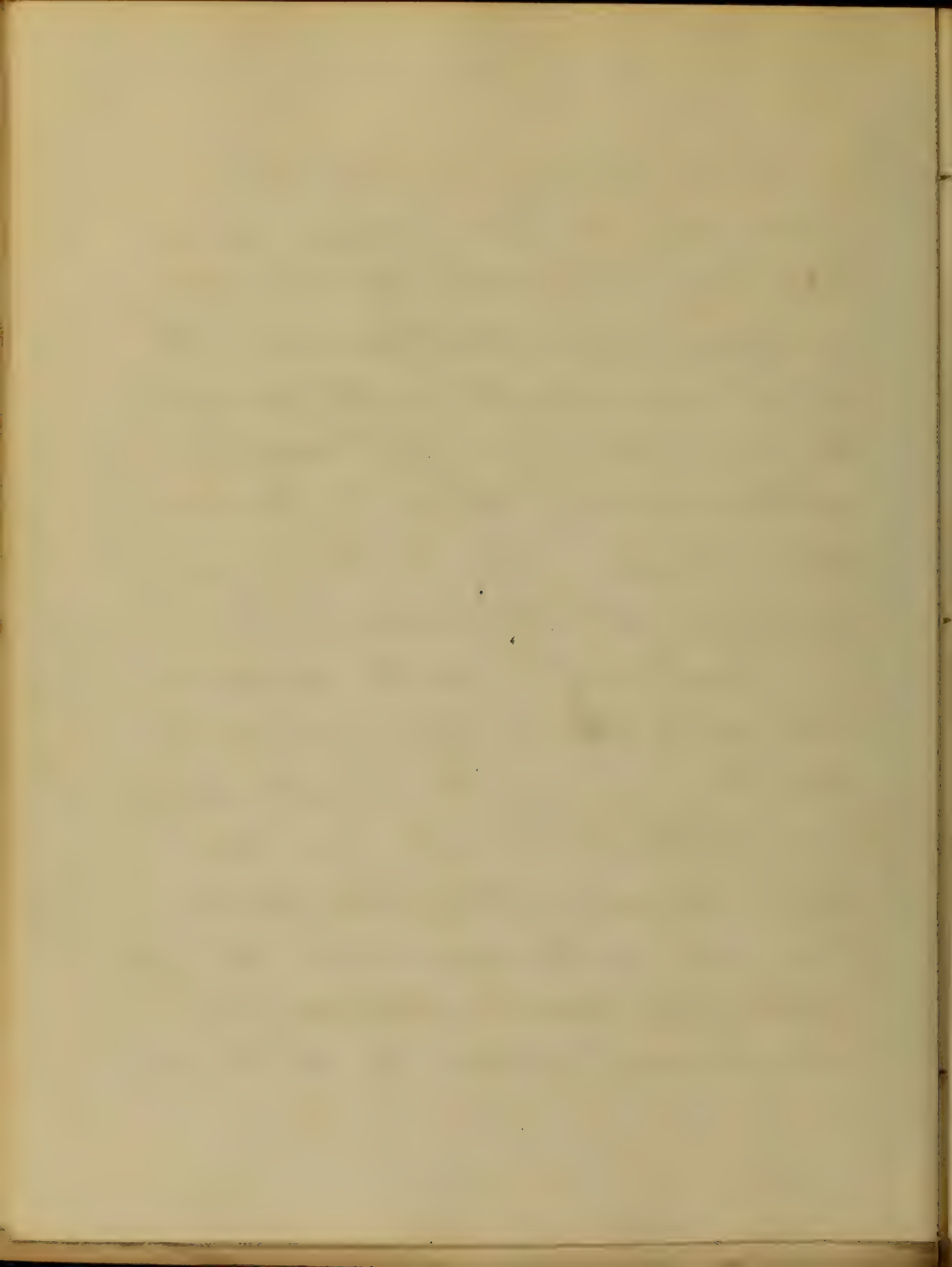


and the extent of lung involved.

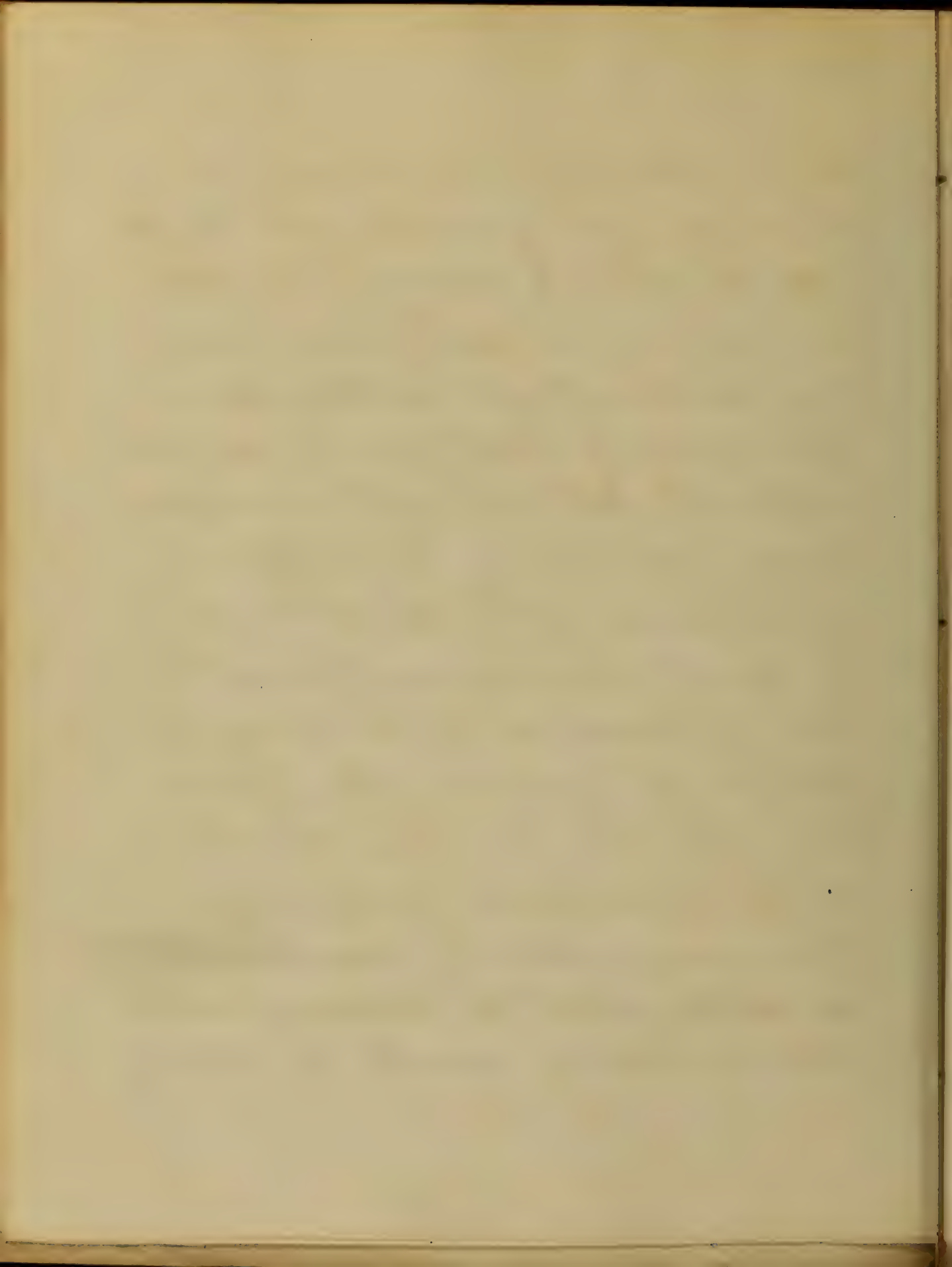
When only one lobe or even an entire lung is involved, if occurring in young and robust persons with proper management, ought always to end in recovery. If it occurs in children or very old people, it is a serious disease. The double form is dangerous at all periods of life.

Treatment. As this disease is believed to be more of an asthenic nature than formerly, the remedies which were so much in vogue, have now fallen almost entirely into disuse.

In some acute cases, where the right side of the heart is distended from an overaccumulation of blood, due



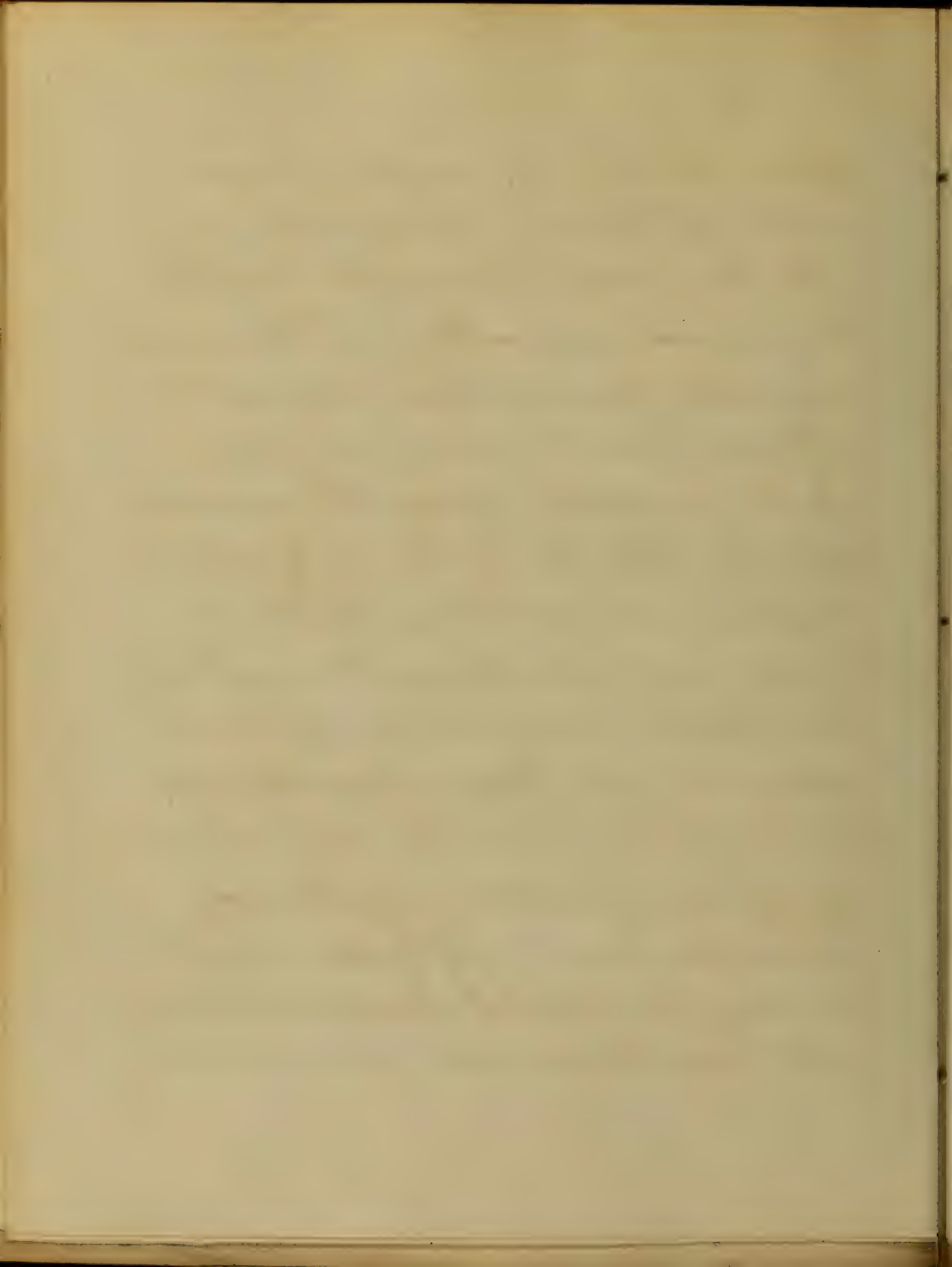
to an obstruction to its passage through the lungs, giving rise to great dyspnoea, congestion of the veins of the neck, and more or less darkly flushed face; we should without hesitation, draw a few ounces of blood from the arm, and relieve the distended heart and sufferings of the patient. It is better in acute cases, if the patient be robust, to draw a few ounces of blood, than have it poured out in the lungs (Prof McSherry). You may then follow this with stimulant doses of opium, which seems to act beneficially in three ways; first, by preventing to a certain extent the depression which follows bleeding; secondly, by allaying



pain; thirdly, by arresting to some extent the tendency to exardation.

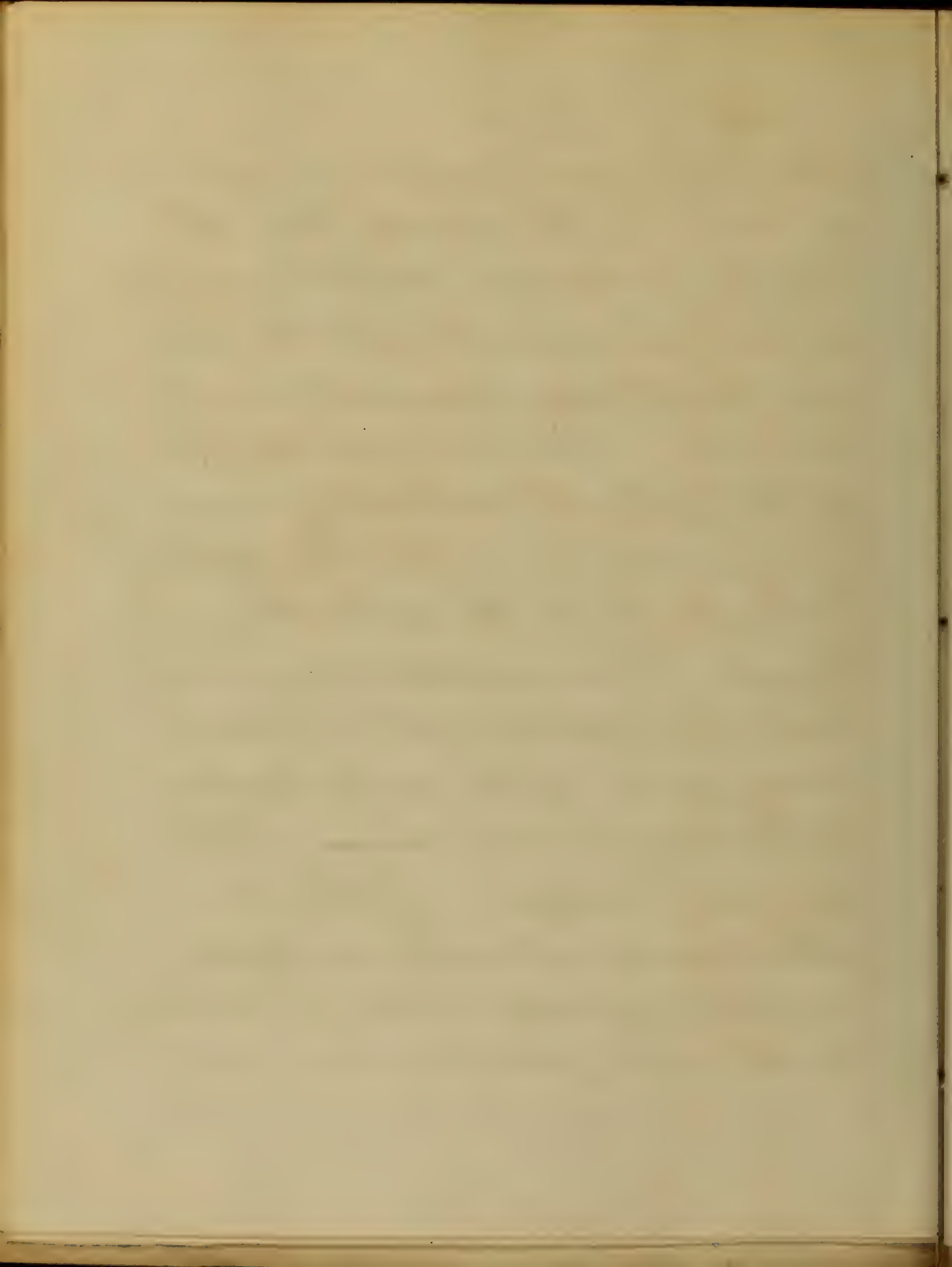
In those cases where active blood-letting is not admissible, and there is considerable pain, marked relief will be obtained from the use of dry cups.

In a majority of cases, the same end can be obtained by the use of saline laxatives and sedatives. If the skin is dry and pulse frequent, small doses of tartar emetic will be useful; or you may give three or four drops of the tincture of aconite with half an ounce of spiritus mindereii, repeated every four or five hours. If fever is high, Quinine in decided doses (from ten to twenty) will break it up; and after it has a-



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bated, you may continue it in ton-
ic doses. In the second stage all
depressing measures should be avoided.
If the bowels are inclined to be cool
you should give occasional doses of
Castor oil. The most essential part
of the treatment in this stage, are sup-
porting measures, - in fact the supporting
treatment should be instituted from
the first. These include tonics, stimu-
lants, and nutritious diet. I have al-
ready spoken of the use of Quinine
in this disease; and various other ton-
ics may be useful. If the pulse is
feeble, frequent, and easily compressed,
we should give stimulants. Where there
is not much prostration, wine will

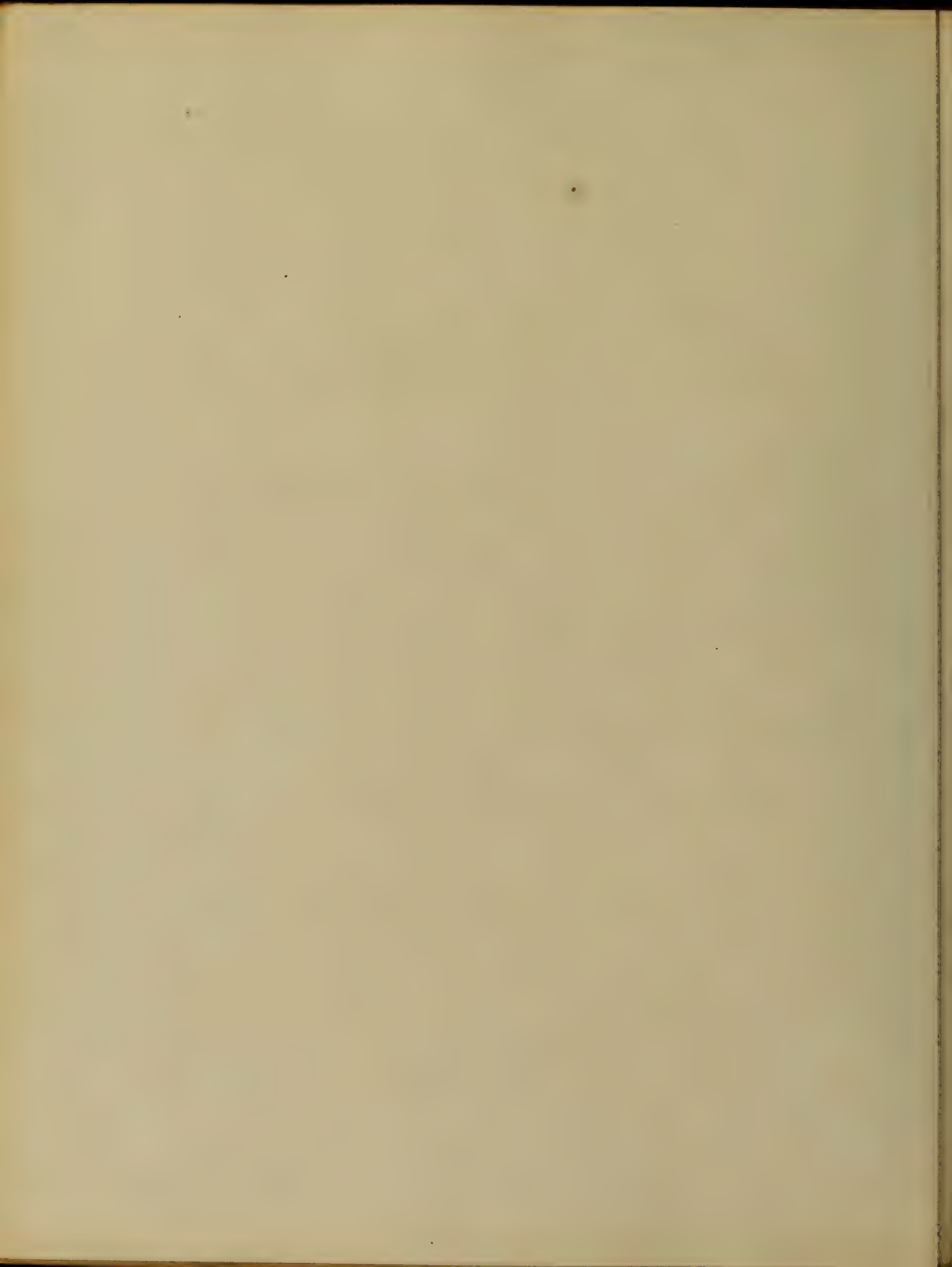


answer every purpose in the quantities of half an ounce, repeated at intervals; but when we want decided stimulation we should give brandy, two ounces or more in the twenty four hours; or if the exudation is slowly removed, ammonia and ipecac will increase the rapidity of its absorption. Counter irritation either by stupus or blisters, assist in its removal, and should be used. The diet is very important in this stage. It should be wholly nutritious, and given at regular intervals. Milk, farinaceous substances, and broths, are among the principle articles, still you may be guided to some extent by the desires of the patient.

The treatment of third stage is strictly supporting. Pain in any stage calls for an anodyne.



Thesis
On
Pneumonia,
Submitted to the Examination
of the
Provost, Regents, and Faculty
of Physic, of the
University of Maryland,
For the degree
of
Doctor of Medicine
by
Luther B. Hurley,
Virginia,
A. D. 1877



Pneumonia.

An inflammation of the substance
of the lung.

Varieties; - According to its seat;
- Single, Double, Lobular. According
to causation, Idiopathic, from
Cold and wet, traumatic, from
injury, Tubercular in children;
And typhoid pneumonia,

Symptoms; The disease is commonly
marked in by restlessness, with
General febrile disturbance.

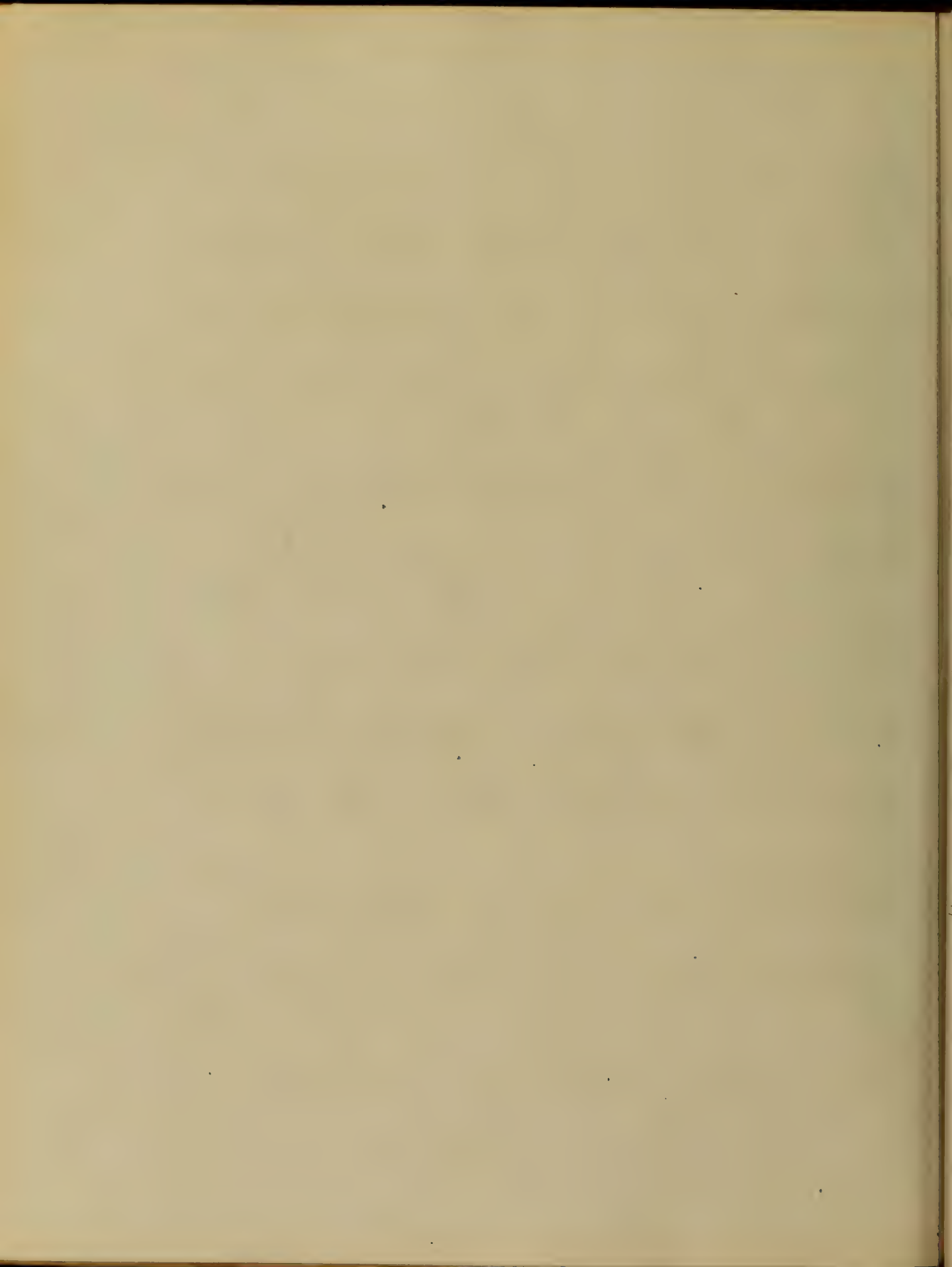
At the end of from one to three
days, there are rigors, some followed
by nausea, Cough, pain in the
side, distressed breathing.



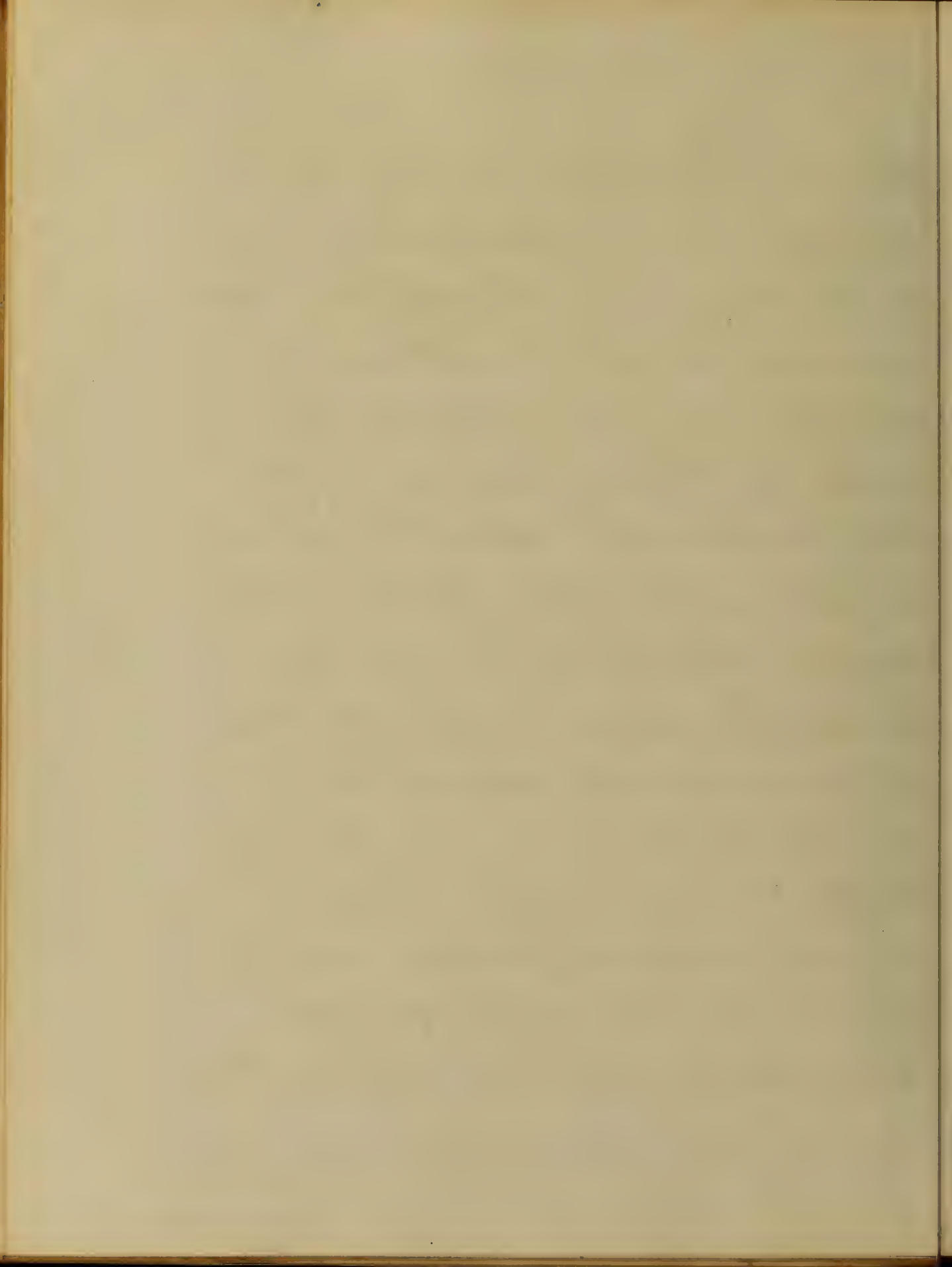
A pulse reaching to 125 to 175
beats in the minute, burning heat
of skin, thirst, loss of appetite,
frustration, headache, and some
times transient delirium,

Stages, Each stage of pneumonia
may be said to consist of three
degrees or stages, The first stage
is that of Congestion, of the pul-
monary Membrane, with dyspnea,
This stage is called the stage of
engorgement,

The second stage is the time
when the affected lobe or a greater
part of it, has become solidified by
the inflammatory exudation,



This stage is called the stage of
solidification, or hebitization,
In the third stage the affected lake
is in one, or, two conditions, If
the disease pursue a favorable
course, the third stage begins when
it is evident that absorption of the
exuded matter is going on, and Con-
valescence takes place, during this
period, This may be called the stage
of Convalescence or resolution,
if the disease pursue an unfavor-
able course, the third stage is one
of suppuration or purulent infil-
tration, and this stage may be
called the purulent or suppurative



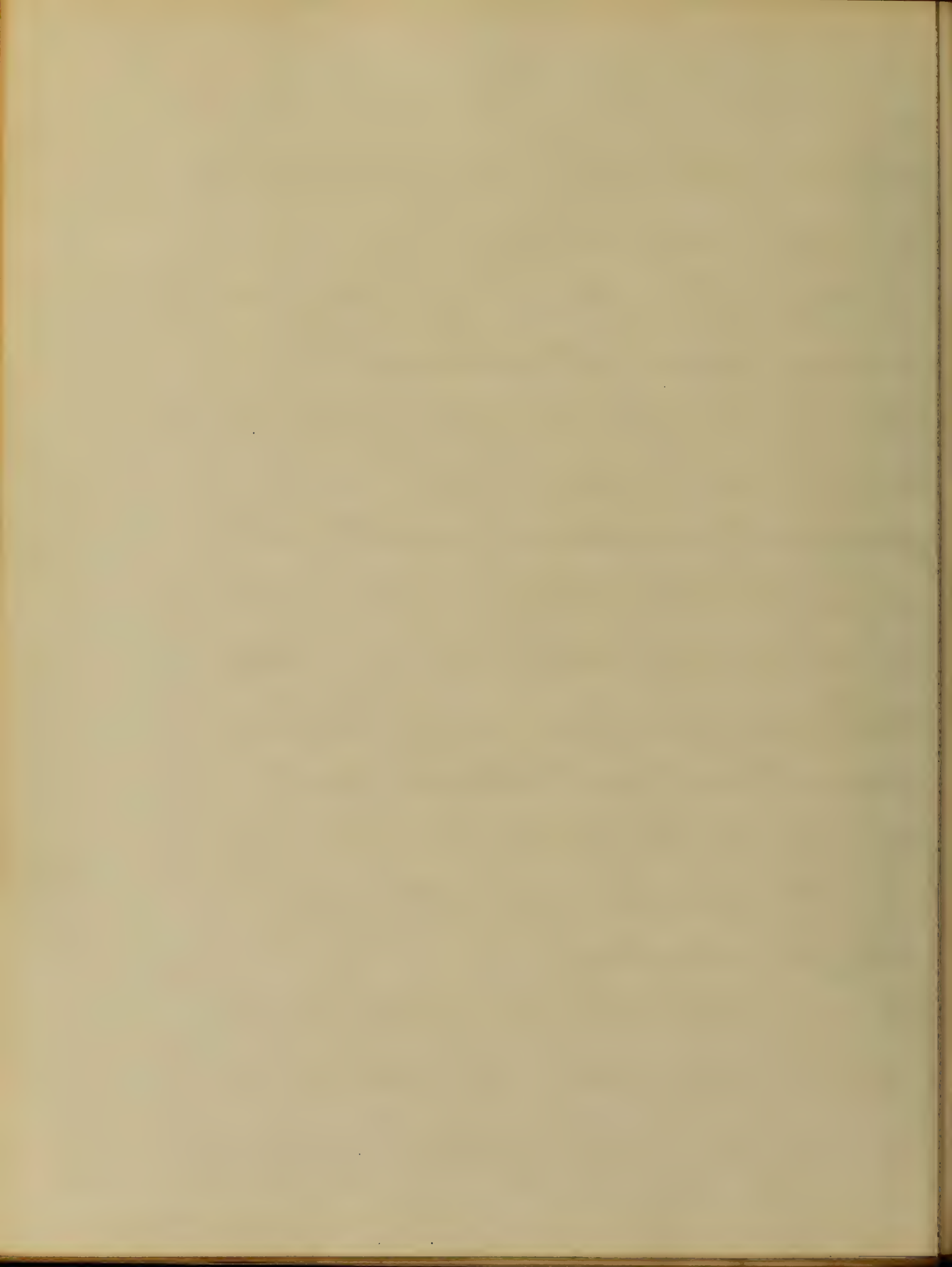
stage, if this stage occur, the disease
generally ends fatally,

In each stage there is a breaking down
-mainly, however, the temperature
rising towards the end of the first
day to 101° or even 102.5° and

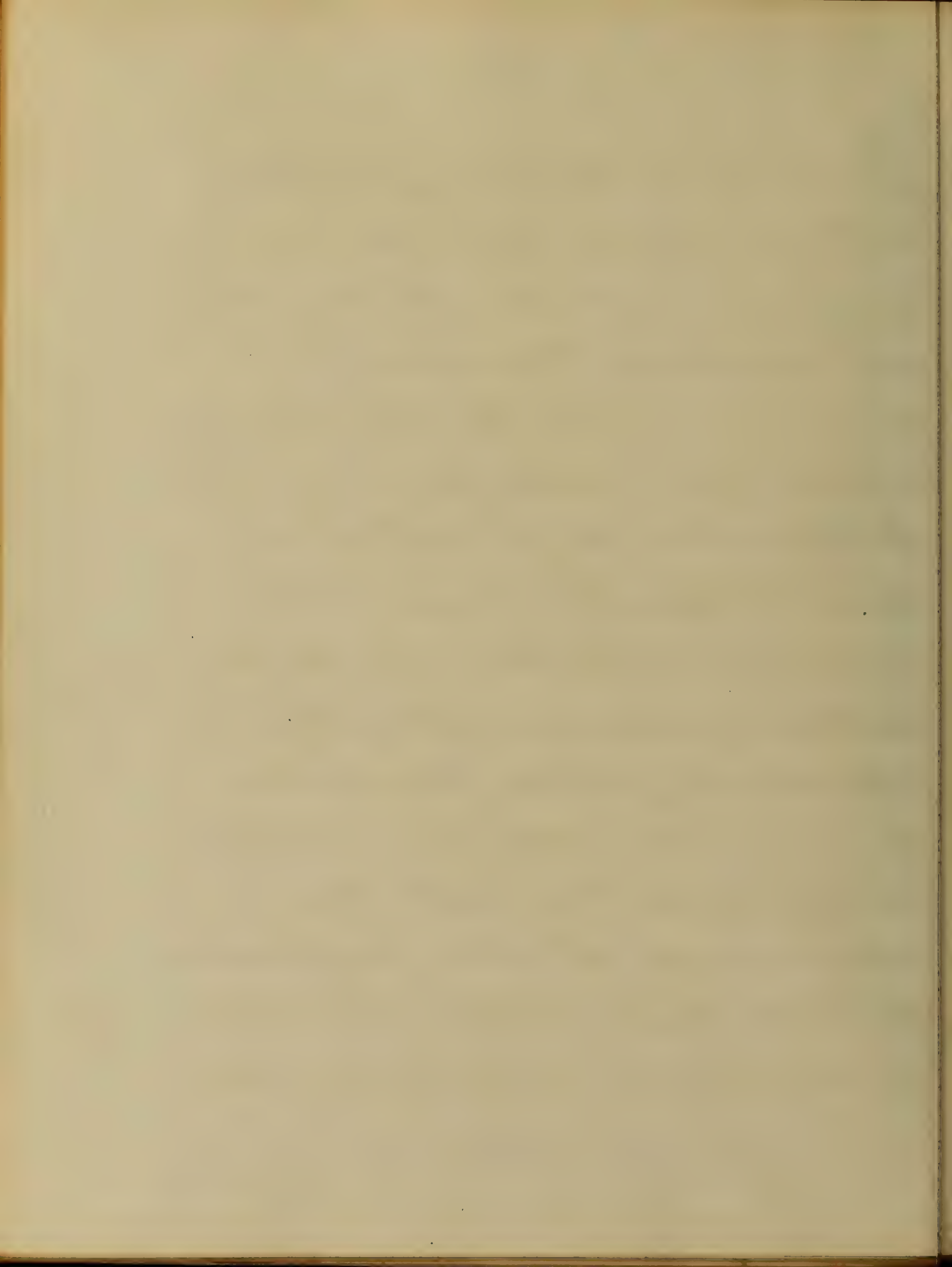
gradually increasing until the
fifth or sixth day, when it will
probably be as high as 105° Fahr. =

Next we have more or less pain in
some part of the chest, most
severe at the commencement
together with accelerated and
shuffled breathing,

There is great depression, with occa-
-sional delirium, and then we

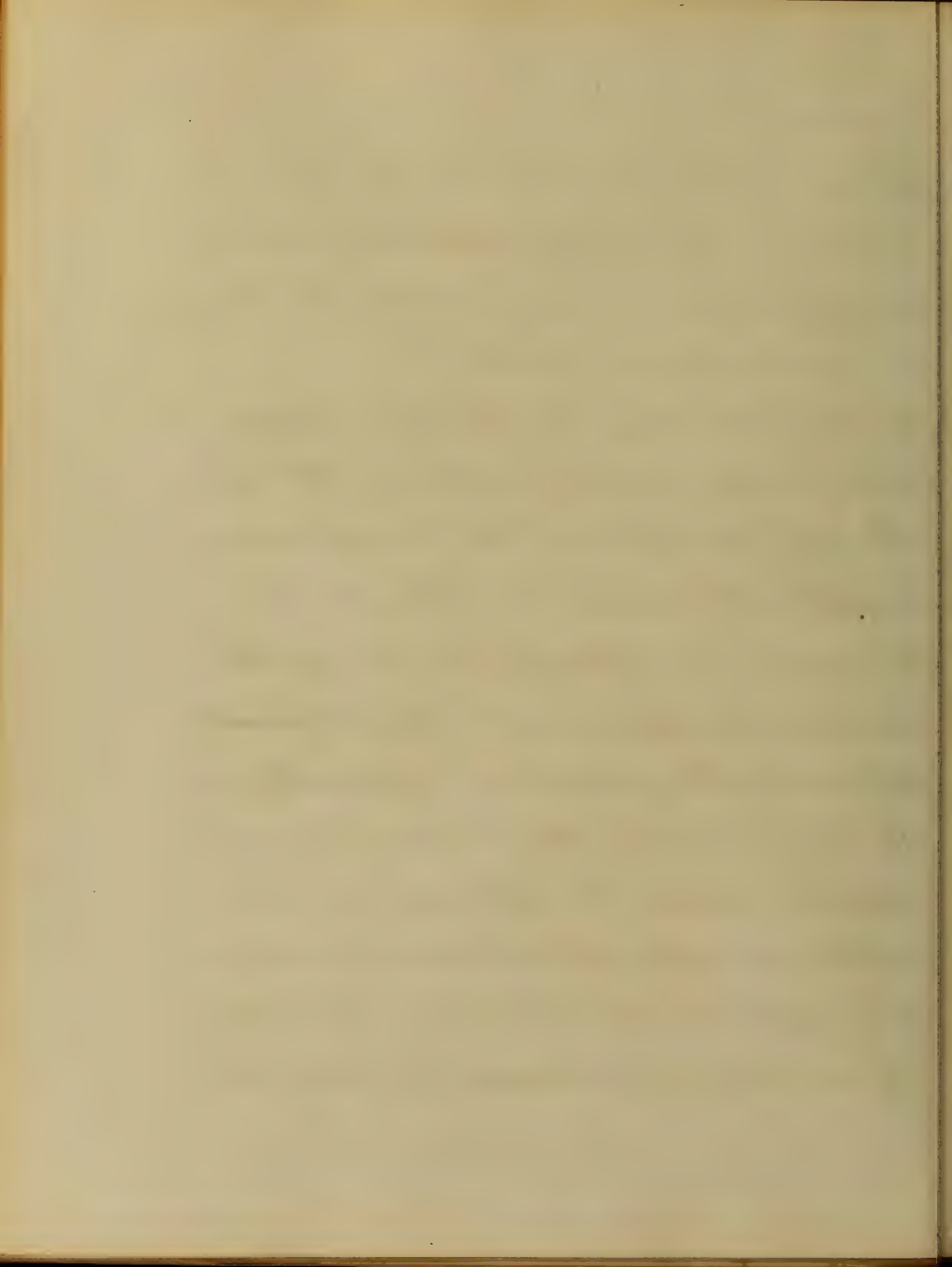


find a very distressing cough
with expectoration of a viscid and
rust colored sputa, which unite
into a mass so tenacious that
even emulsion of the vesset in
which it is contained will not
detach a particle of it; if these
sputa be minutely examined they
will be found to consist of mucus,
epithelium, exudation matter, blood
cells, and oil globules; The presence
of sugar may some times be detect-
ed by Tromer's test, while there is
also an excess of chloride of sodium
and as the blood contains an usual
amount of fibrin, Coagulation may



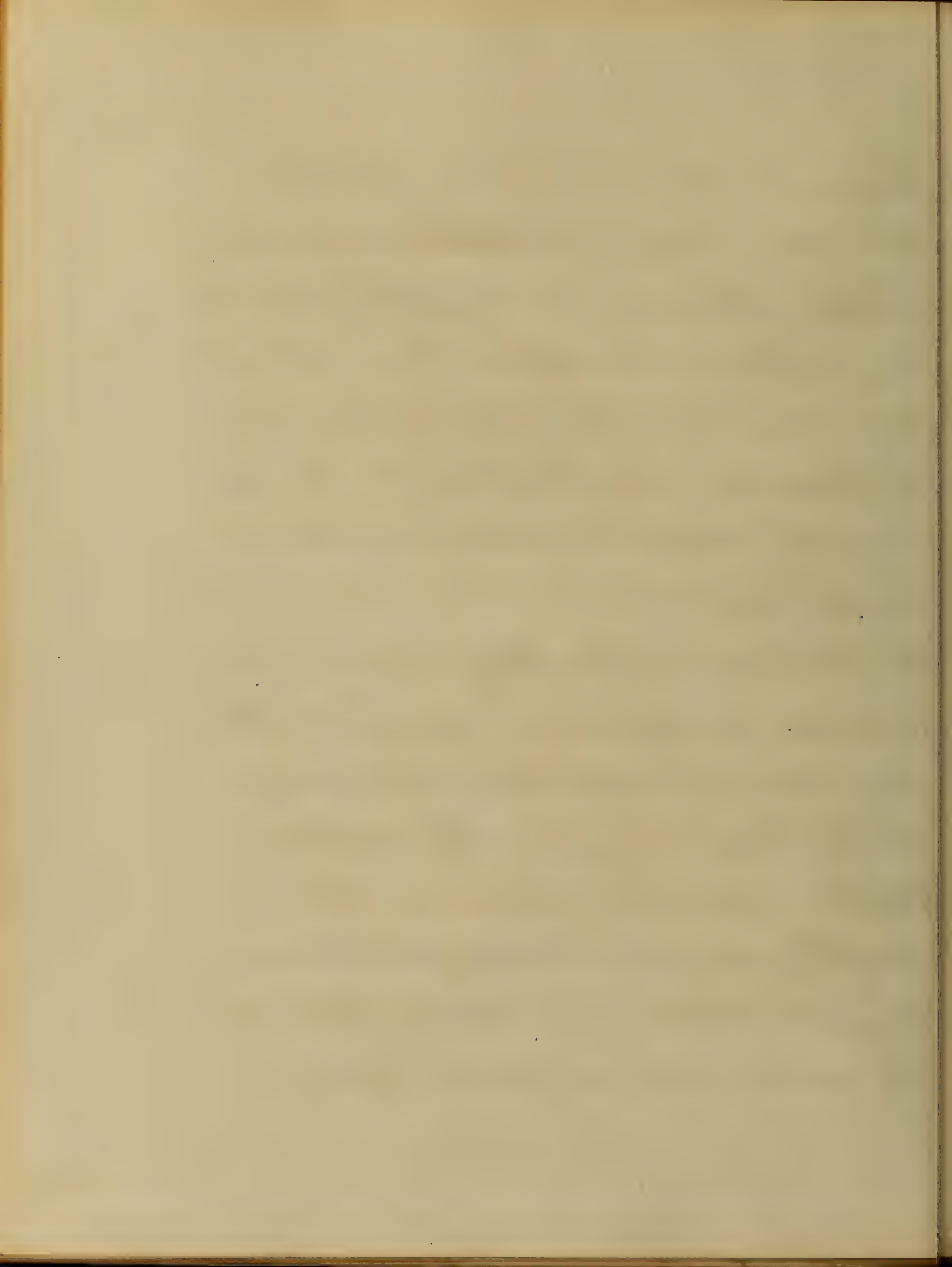
from in the right side of the
heart, & in the pulmonary Arteries,
and give rise to urgent dyspnoea,
or even sudden death,

In the first stage, or that of in-
flamment, is that in which the air cells of
the affected part of the lung becomes
loaded with serum or blood and
serum. The inflamed portion of the
lung is of a dark red color externally
and on cutting into it, a quantity of
dark red and frothy looking serum
escapes, while its appearance some-
what resembles the spleen, its elas-
ticity, and sponginess being diminished.
If the Chest be listened to when the

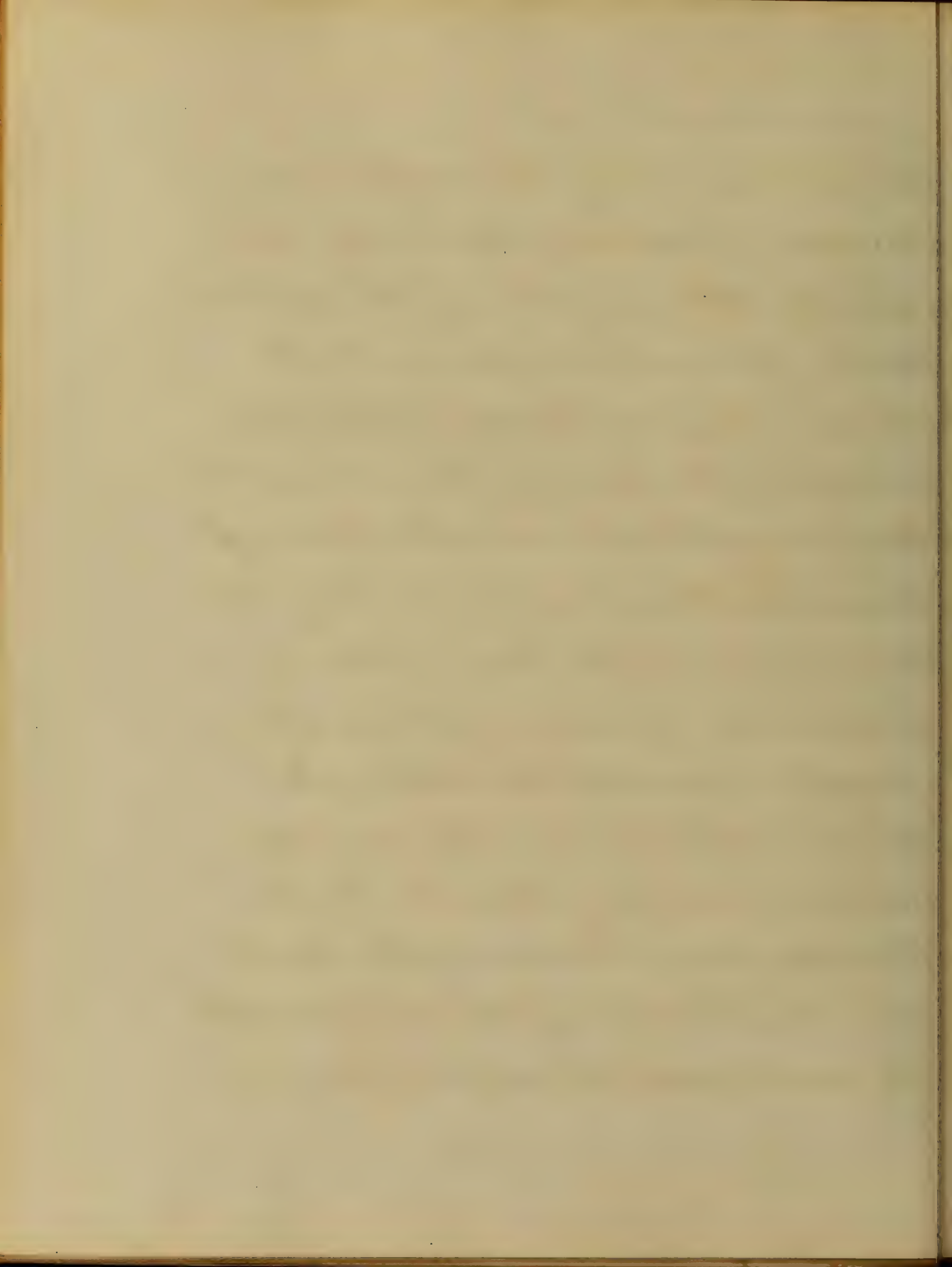


lung is in this condition, we will hear very fine crepitation, a sound which is known as Minute Crepitation or Crepitant rouschus, If a lock of one's own hair be rubbed between the fingers and thumb close to the ear, a sound will be produced nearly resembling it.

The natural respiratory or Vesicular murmur is still heard mingled with this Minute Crepitation, especially at the beginning; as the inflammation advances, however the healthy sound is nearly displaced or quite displaced by the morbid one, Percussion, also at first affords



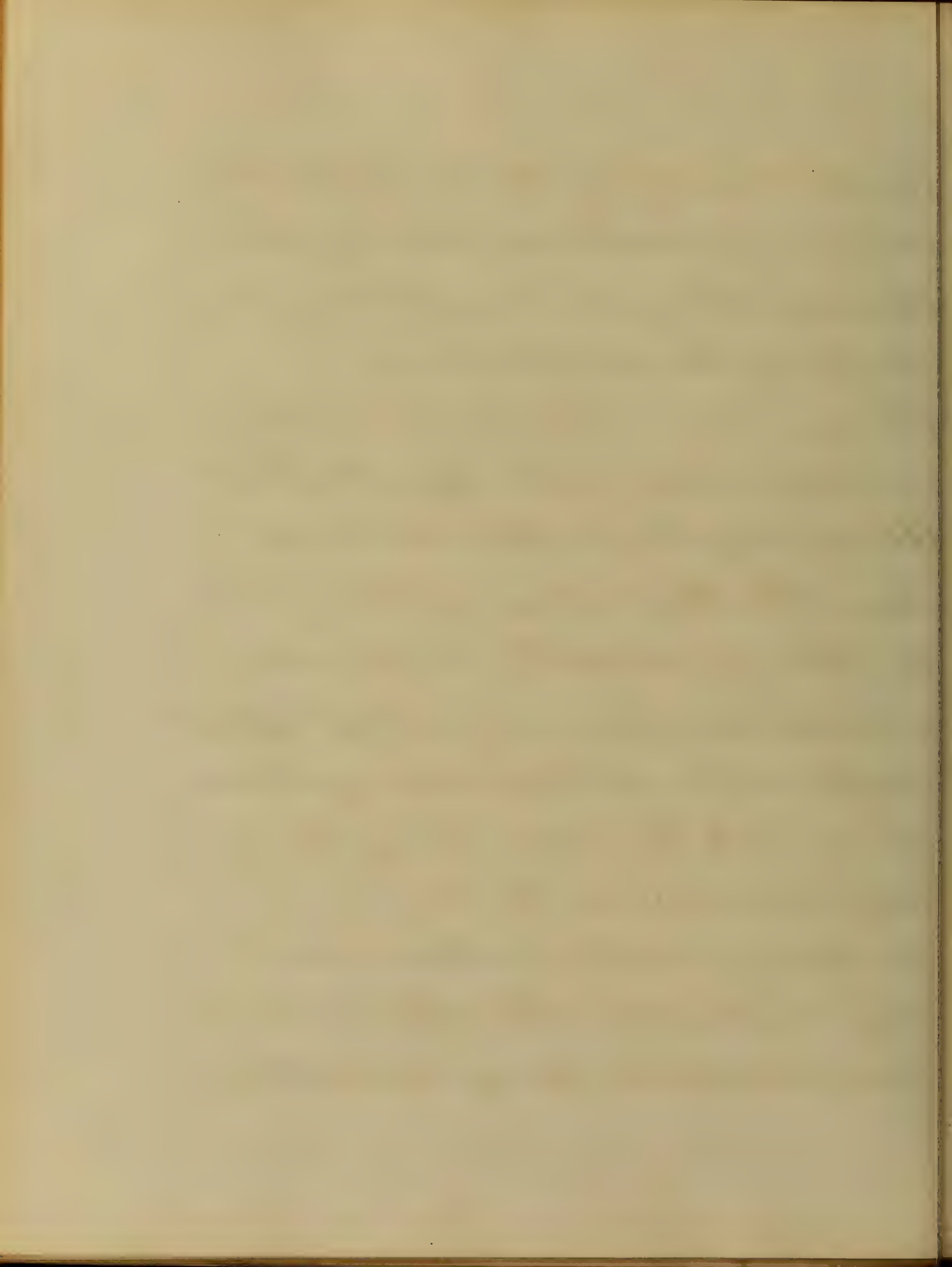
Almost, or nearly the natural res-
-onance,, gradually this becomes de-
-cidedly obscure, Nam if the inflam-
-mation proceed it passes in to the
Second stage, or that of hepatisation,
in which the spongy character of the
lung is quite lost, and the texture of
becomes hard and solid, resembling the
out surface of the liver, when it is
said to be hepatised, if now we
practice auscultation, neither the
minute crepitation, nor the vesicular
murmur will any longer be heard,
Bronchophony however still exists
more particularly if the inflammation
be seated near the upper part or



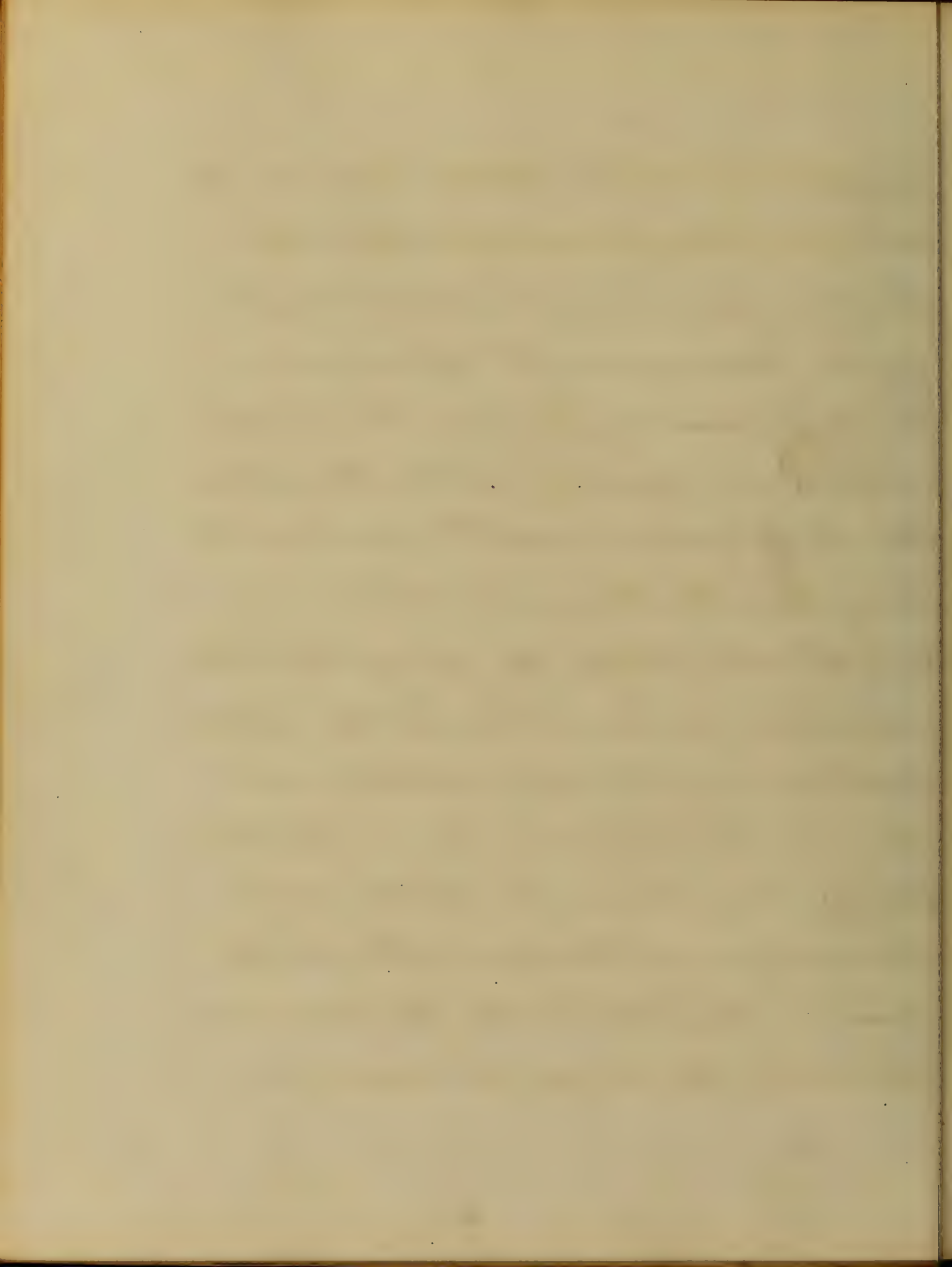
in the vicinity of the root of the lung,
and it is accompanied also by bron-
chial, breathing, these sounds being con-
ducted by the solidified lung,

The resonance on percussion is dull
over the whole of the affected part,
Advancing still further, we now
have the third stage of Pneumonia,
or that of resolution, or purulent
infiltration, which consists of diffused
suppuration of the pulmonary tissue,
parts of the lung remaining dense
and impermeable to the air,

In many instances there is no
true suppuration, the appearance of
such a condition being simulated by

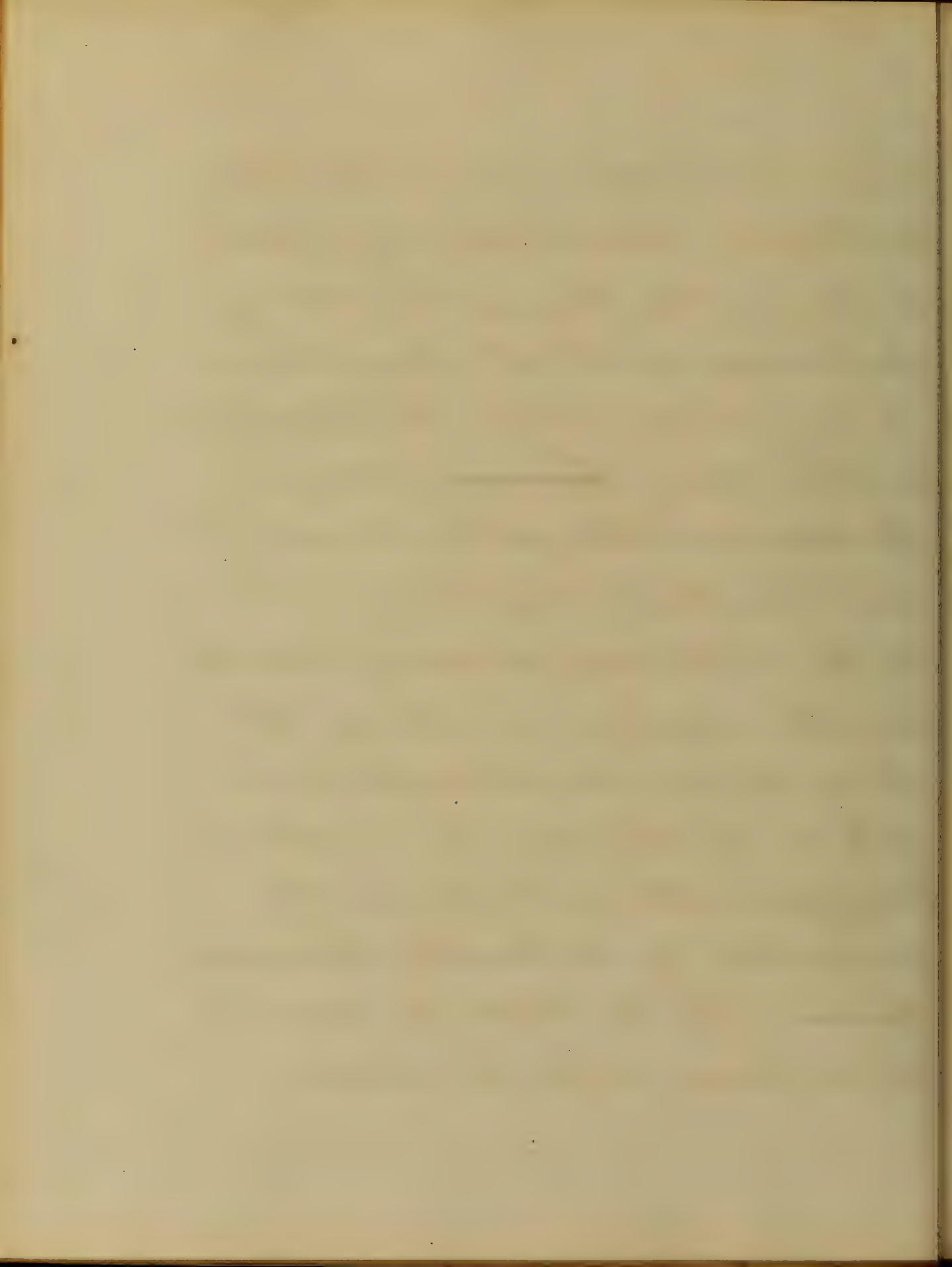


liquified & undation matter, circumscribed
Abscess is very uncommon, but dis-
-fused suppuration is said to be a fre-
-quent consequence of inflammation
of the pulmonary tissue, There is no
physical signs by which this stage
can be diagnosed, until part of the
lung breaks down and the pus is
expectorated, large gurgling crepitation
will then be heard, Should the inflam-
-mation subside before the stage of
purulent infiltration, as it fortu-
-nately does, then the febrile disten-
-sion begins to decrease, the tempe-
-rature drops towards the normal
standard, the cough becomes less



irritable, and the general distress
mitigated. Still the frequency of the
pulse, and the hurried breathing
continues until the lung begins
to loose its solidity. The hepaticized
condition may however remain,
permanent though as a rule it
will gradually pass away.

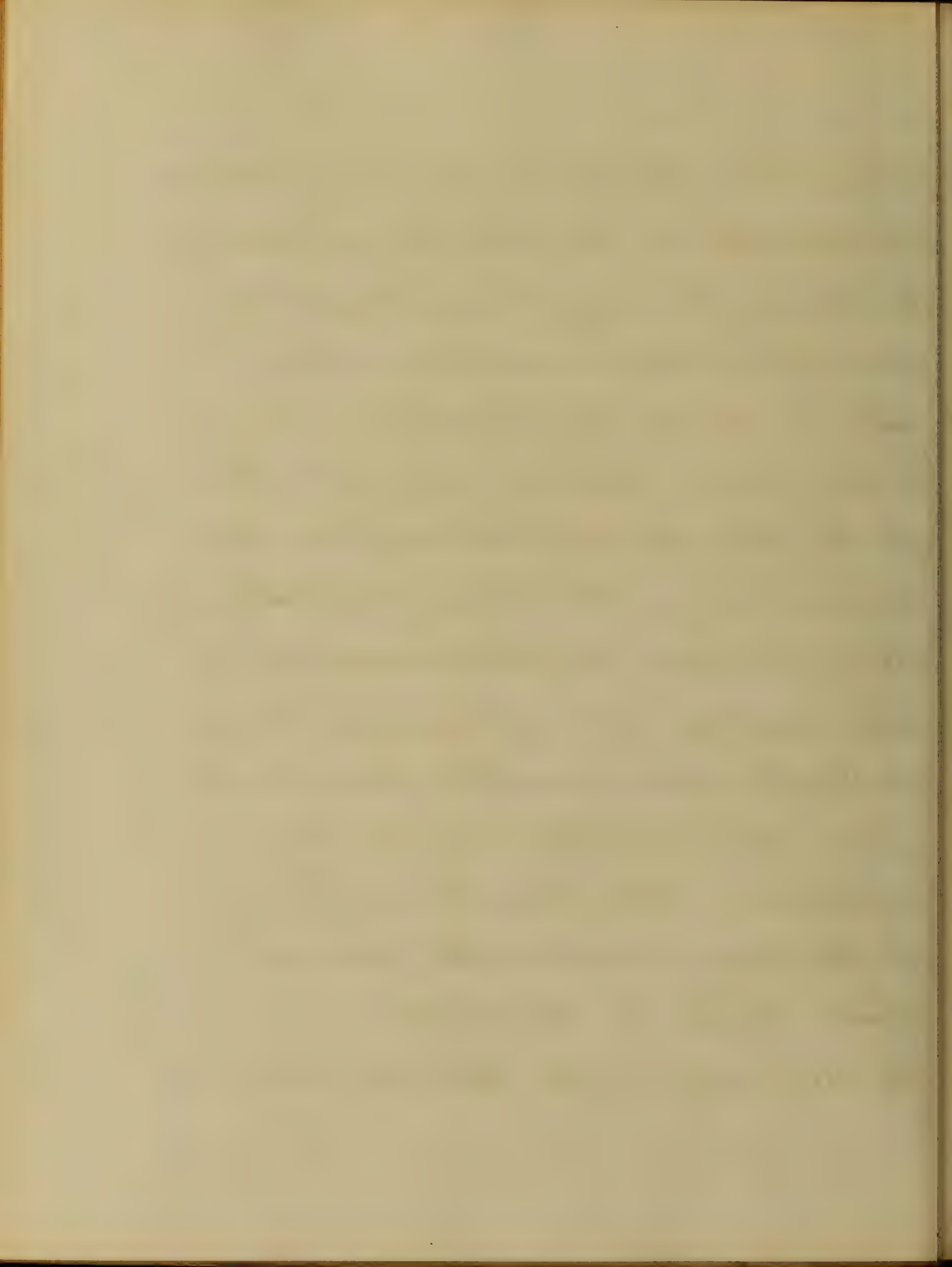
In the latter case, one will find the
air the slowly re-entering the
lung, as will be indicated by a
return of the minute crepitation,
mingled with, and subsequently
superseded by the healthy vesicular
murmur, If the Urine be examined,
as the disease begins to advance



there will be found to be, a gradual
diminution of the Chloride of Sodium,
And when the lung becomes completely
solidified, there will be a total
absence of all the Chlorides.

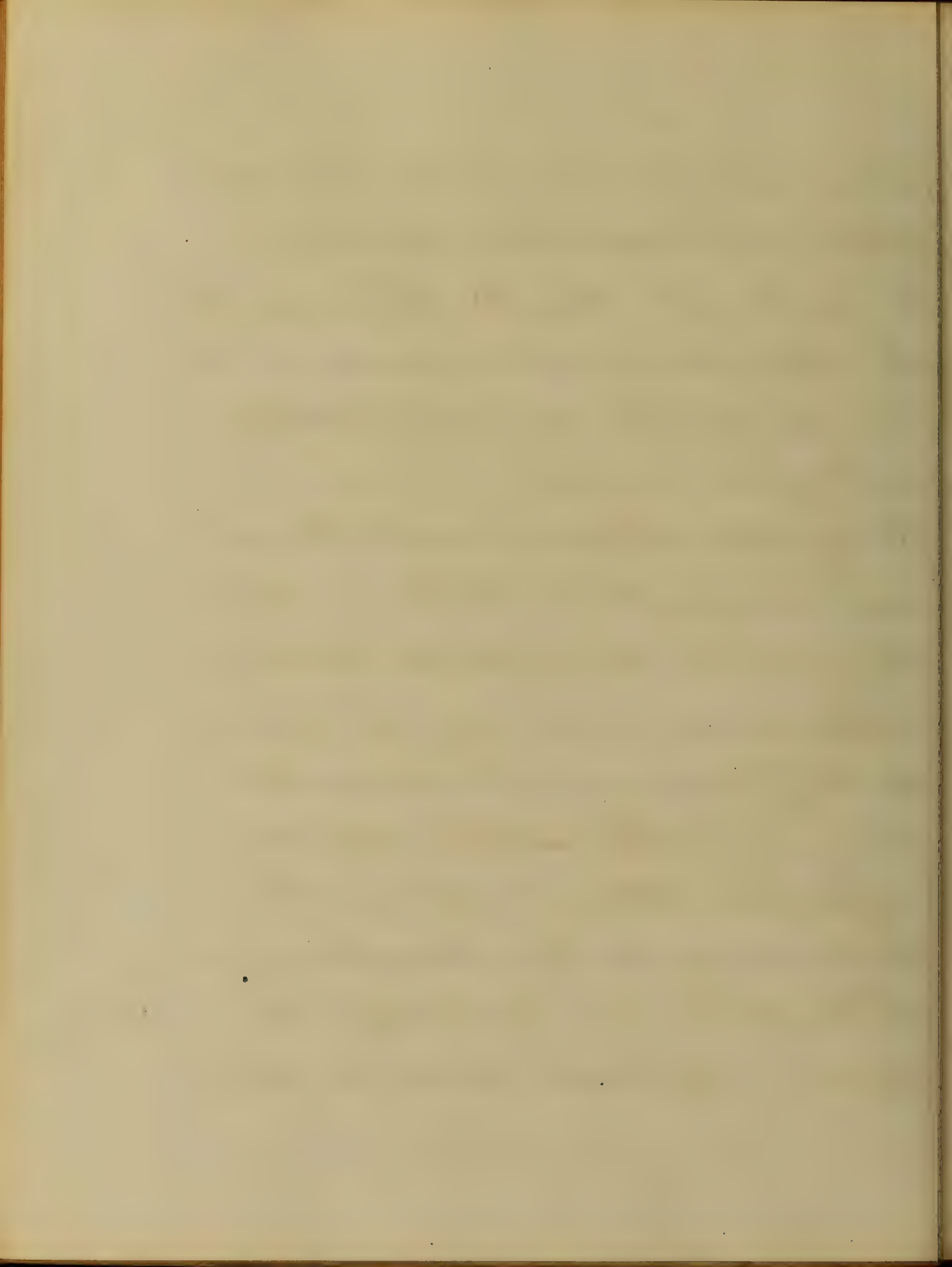
There is reason to believe that the absence
of the Chloride of Sodium, from the
urine during the stage of hepatization
depends upon the determination of
this salt to the inflamed lung,
and that when resolution occurs, this
force of attraction ceases, and
whatever salt has been retained
in the lung is reabsorbed, and ap-
pears again in the urine.

The deficiency of the Chloride of Sodium

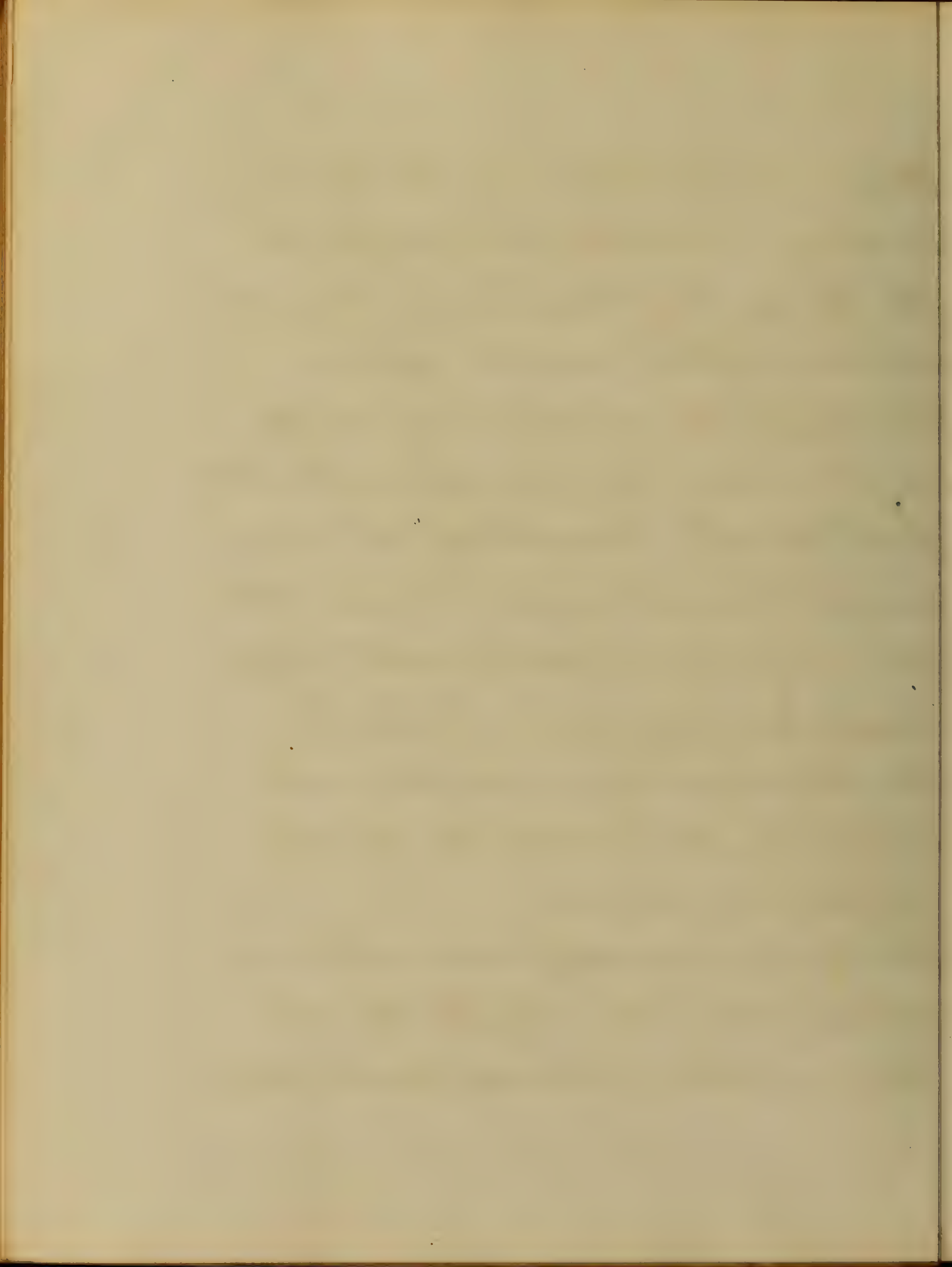


is not peculiar to, pneumonia, nor,
Acute inflammations generally,
It is thought that the deficiency of
the Chloride of Sodium, is due to the
loss of appetite, and the saltless
diet of the patient,

Very often depressed Constitutions, as
well as when the Constitution is con-
taminated with Syphilis, Acute
inflammation of the lung terminates
in diffused or in circumscribed
Gangrene, Abscessation may also
arise from other conditions than
pneumonia, as, for example, from
tubercle, Cancer, hemorrhage, the
presence of Mordid poison in the

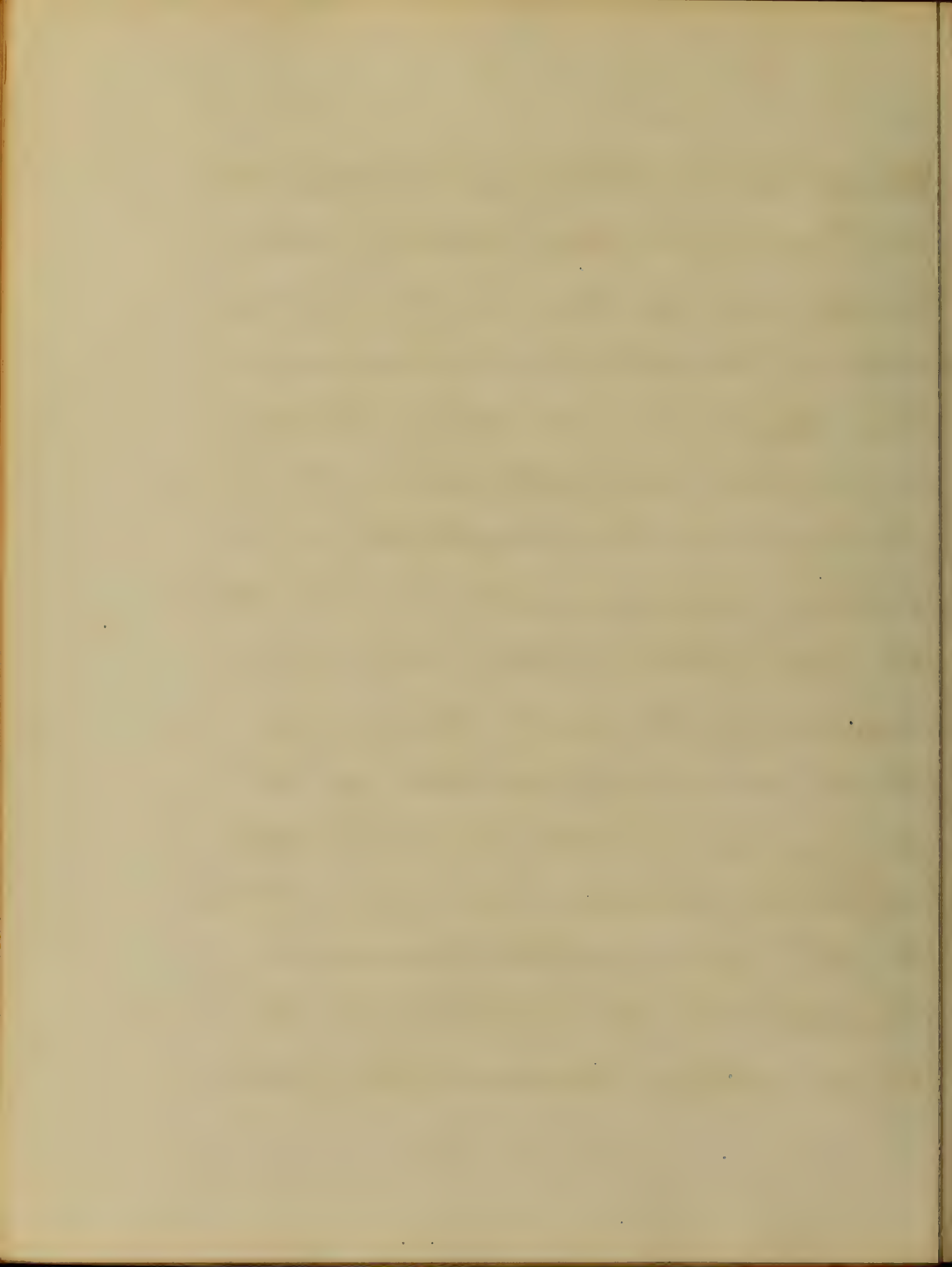


Blood, and disease of the brain,
causing purulent inflammation of
the lungs, It occasionally occurs in
children after eruptive fevers,
The characteristic symptoms of such
an occurrence, are an intolerable state
of the breath, resembling the odor
which proceeds from external gan-
genous parts, together with dysp-
noea, and very great prostration,
The physical signs are those of
softening, and excavation of the
pulmonary tissue,
The disease is usually more extensive
and progresses more rapidly in
diffused, than in circumscribed gangrene



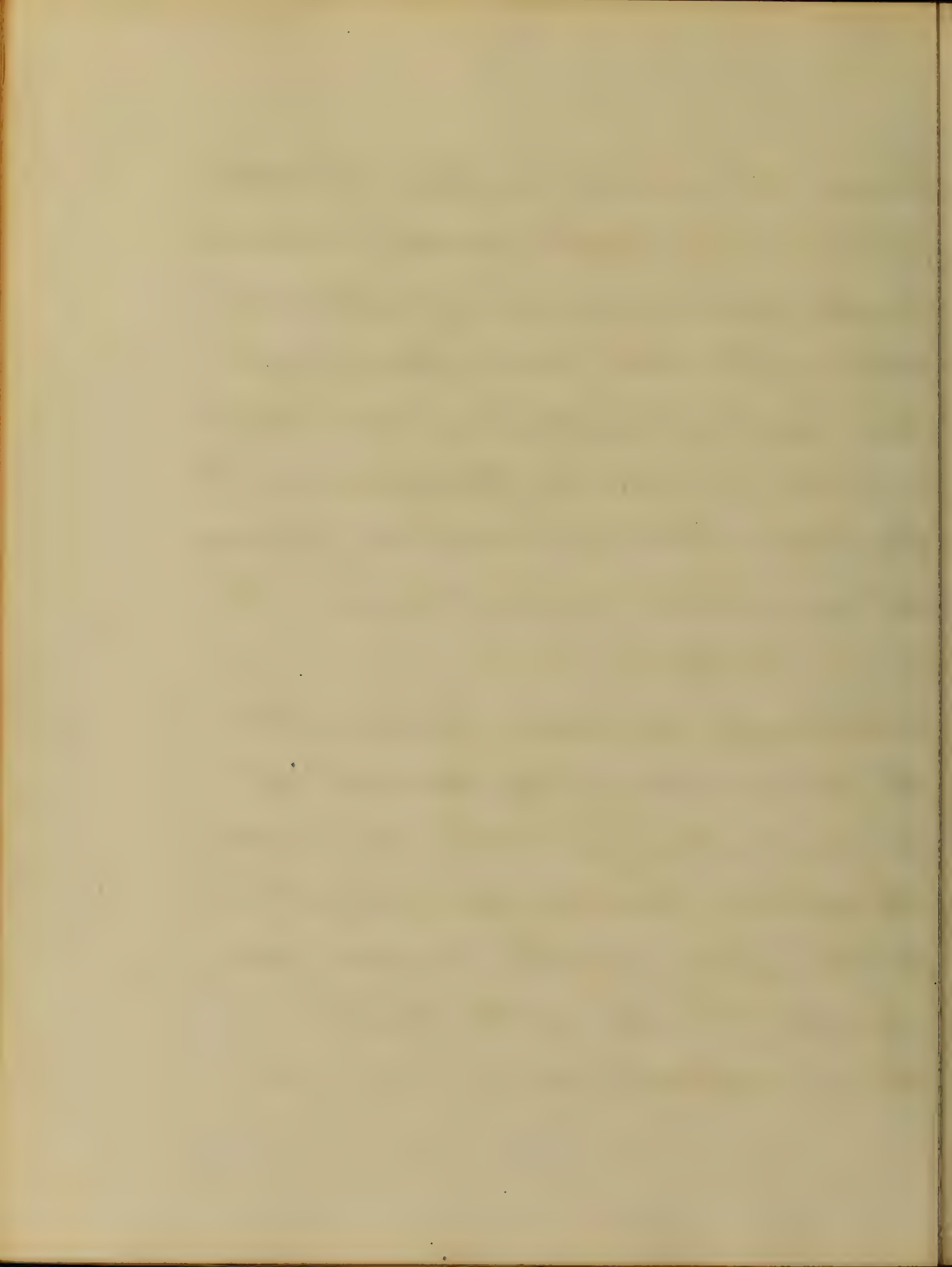
Unless the mortified part be very small
death will in most cases result,
In very old age, and in some forms of
insanity, an attack of pneumonia,
some times runs its whole course,
and results in death, before its
presence has been suspected,

Chronic pneumonia, or, as it is called
by some phthisis, may occur as a
sequence of the acute disease, or it
can be set up by irritation of the
Gummata in advanced stages of
Syphilis, However produced, it now
as then gives rise to persistent
Consolidation of a portion of the
lung, Slight haemoptysis ~~some~~



times occurs, accompanied with
feverishness, night sweats, emaciation,
Cough, pallor, a sense of oppression
within the chest, and loss of appe-
tite, Iodide of potassium, and bark
or Iodide of iron, or Ammonia with
bark, and Cod-liver oil or Glycerine
and good diet, are the remedies to
be trusted to.

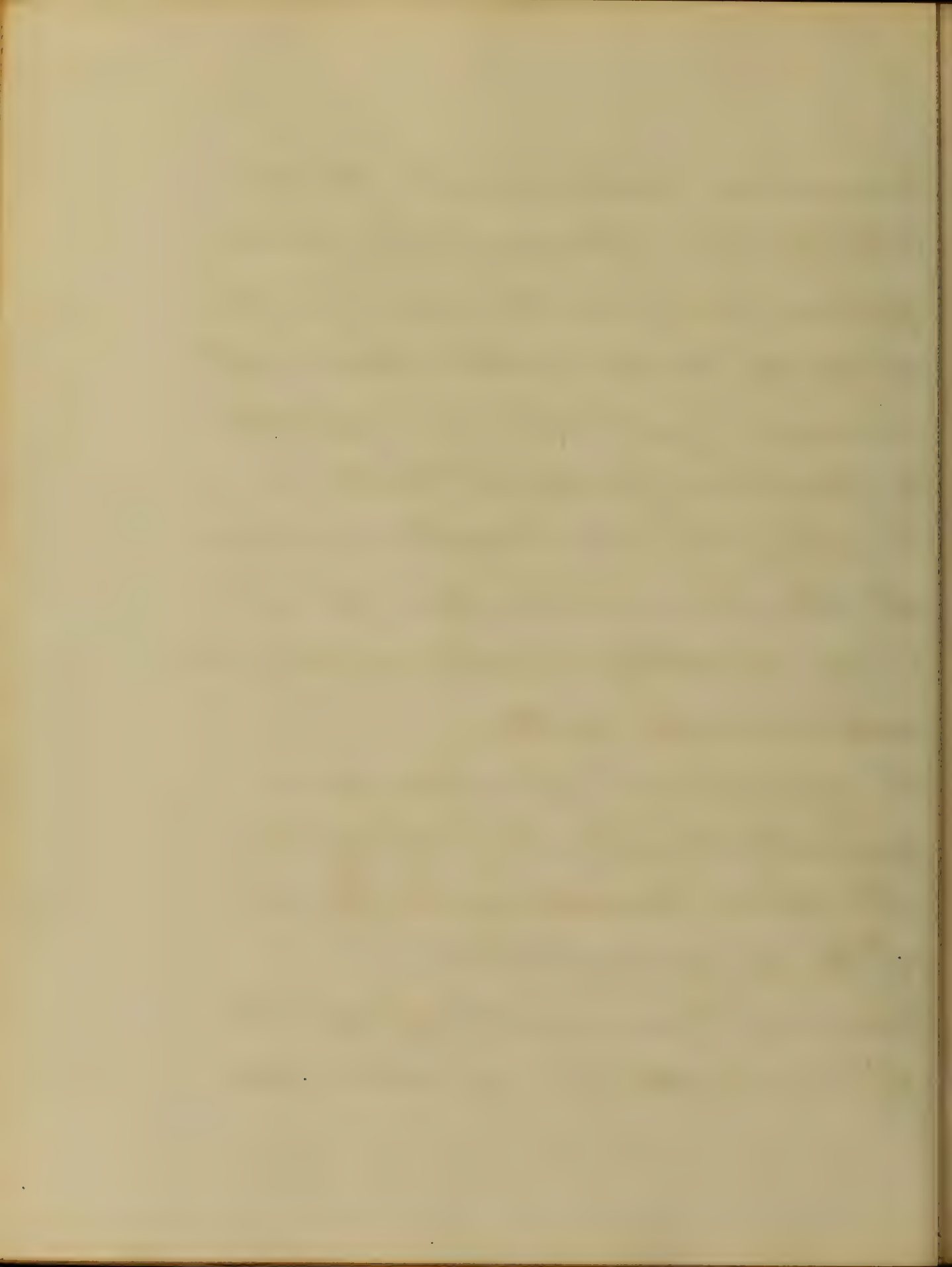
Pathology, It seems certain that
the disease essentially consists of
An exudation, into the air sacs
themselves, There is no interstitial
tissue inflammation, as was once
taught, by the older writers,
because there is no



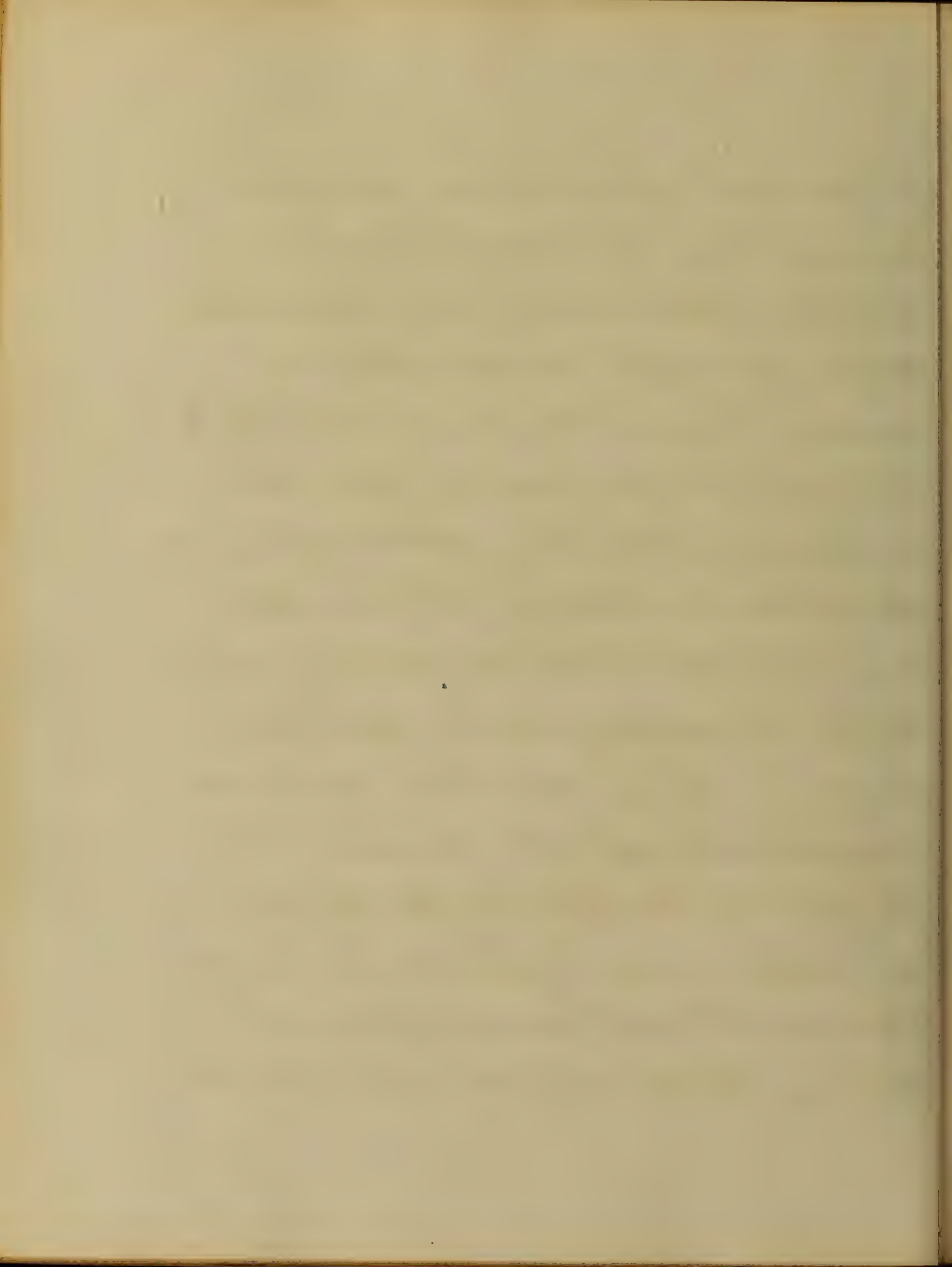
Connective tissue between the air cells to get inflamed, The matter poured out from the vessels in the walls of the air sacs consists of serum, lymph and subsequently of purulent fluid, At the same time that the cell cavities get filled, the thin fibrous structure of their walls, doubtless becomes infiltrated with exudation matter,

The exudation in pneumonia is generally supposed to come from the blood circulating in the branches of the pulmonary arteries,

Cause of Pneumonia, No period of life is exempt from it, as a rule

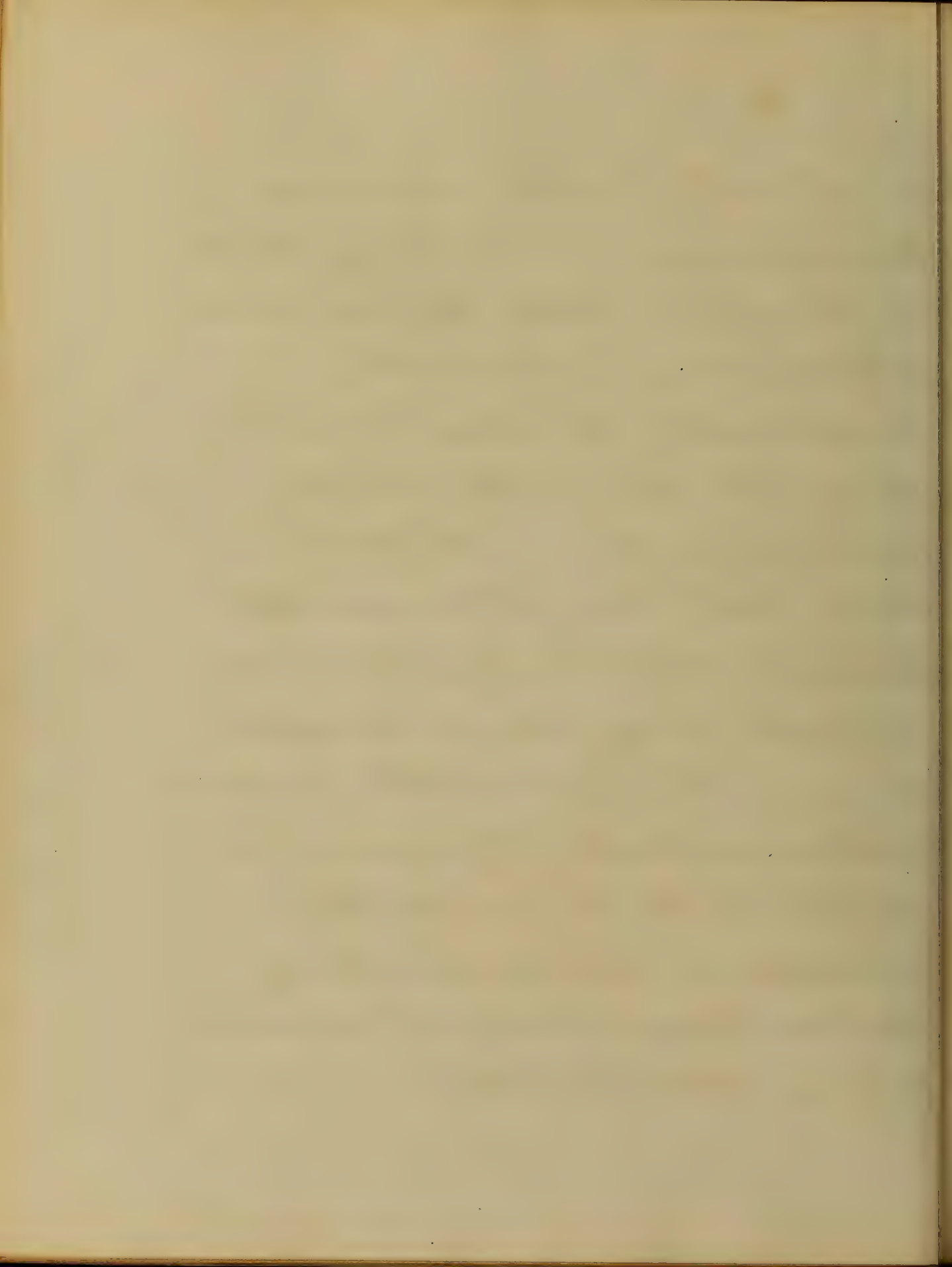


it does not often occur under five years of age, it is most frequent between fifteen, and forty, Pneumonia occurs more often in men than in women, Persons employed out doors are more apt to have it, than those employed within doors, that infrequently the attack is attributed to some unusual exposure, such as sleeping out doors, or working in the cold and wet, Pneumonia sometimes occurs as a complication of other diseases, It is frequently developed in the course of Typhus, and Typhoid, fever, and Rubella, It most generally occurs during the winter and spring months

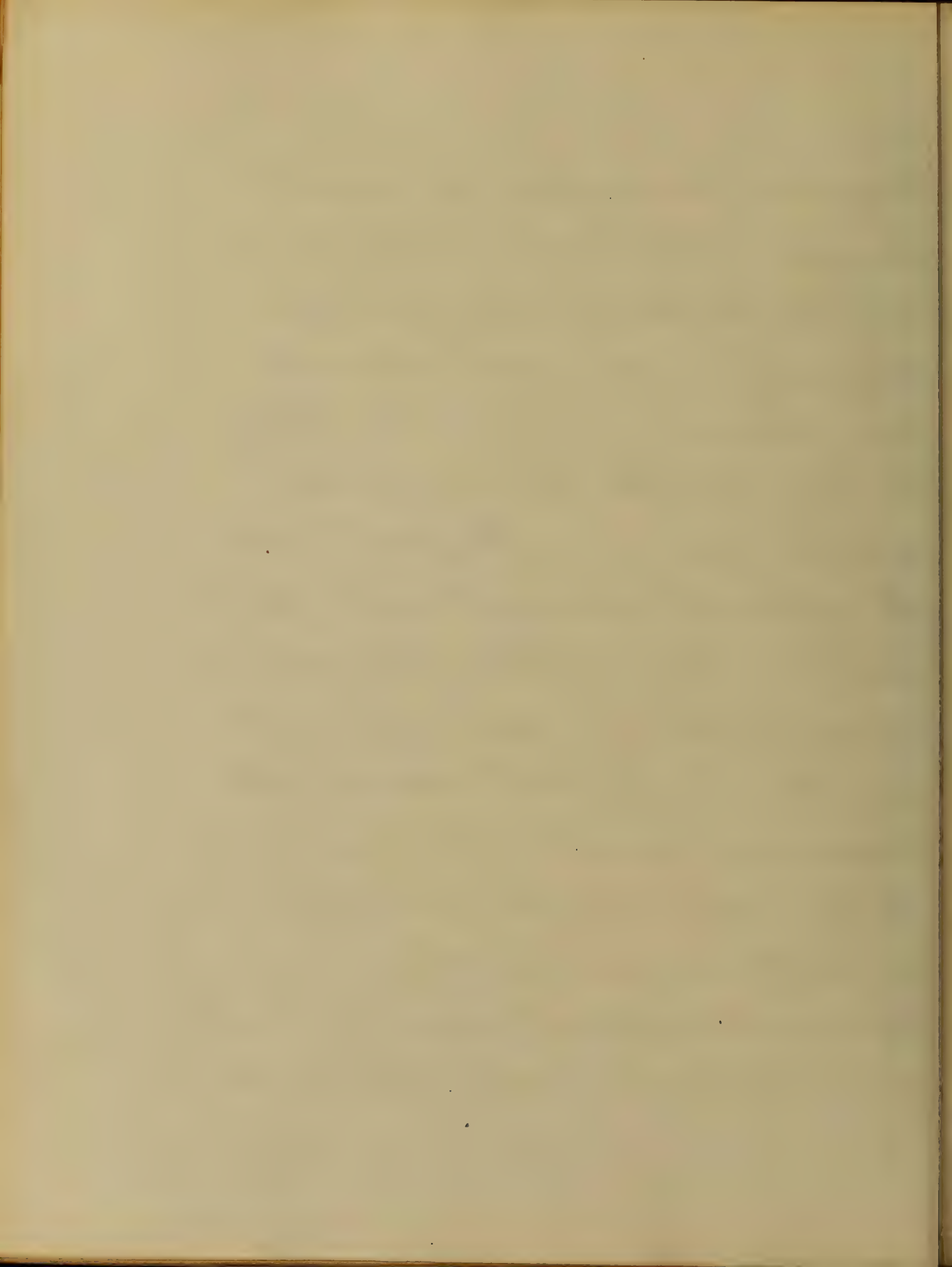


in the Northern states. Cases are
more numerous in the spring, while
in the Southern States they are most
apt to occur in the winter,

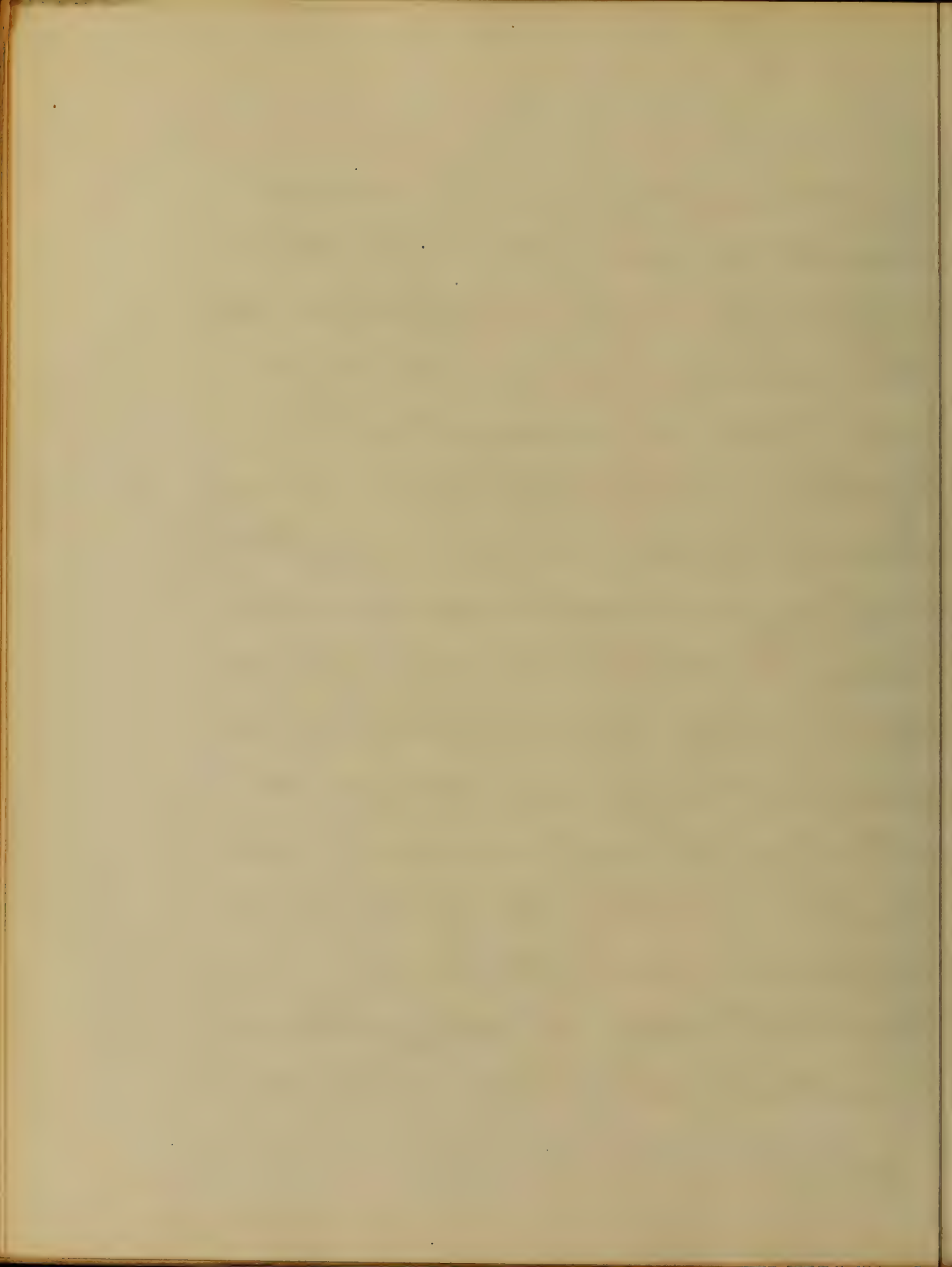
In this Country, the disease occurs in
the Middle and Southern States,
much later than, in the Northern
States. Most cases of Pneumonia, are
developed spontaneously, and is not
referable to any obvious causation
or agency. The disease is often produced
traumatically, by injuries in-
flicted, on the Chest, and thus
produced, the inflammation rarely
extends beyond a lobe, and may extend
only over a part of a lobe,



Pneumonia, may affect one or both
lungs, or, technically speaking it
may be double or single, the right
lung suffers more often than the
left; about one in eight cases both
are affected, The lower lobes are
more susceptible to inflammation than
the upper, The average duration of the
disease is about fifteen days, when
un-complicated, if complicated, not
less than twenty, Mild cases are often
convalescent on the ninth day, In
fatal instances death occurs, between
the sixth, and twentieth days
Pneumonia with out a degree of bronchi-
tis seldom exists, It may happen with

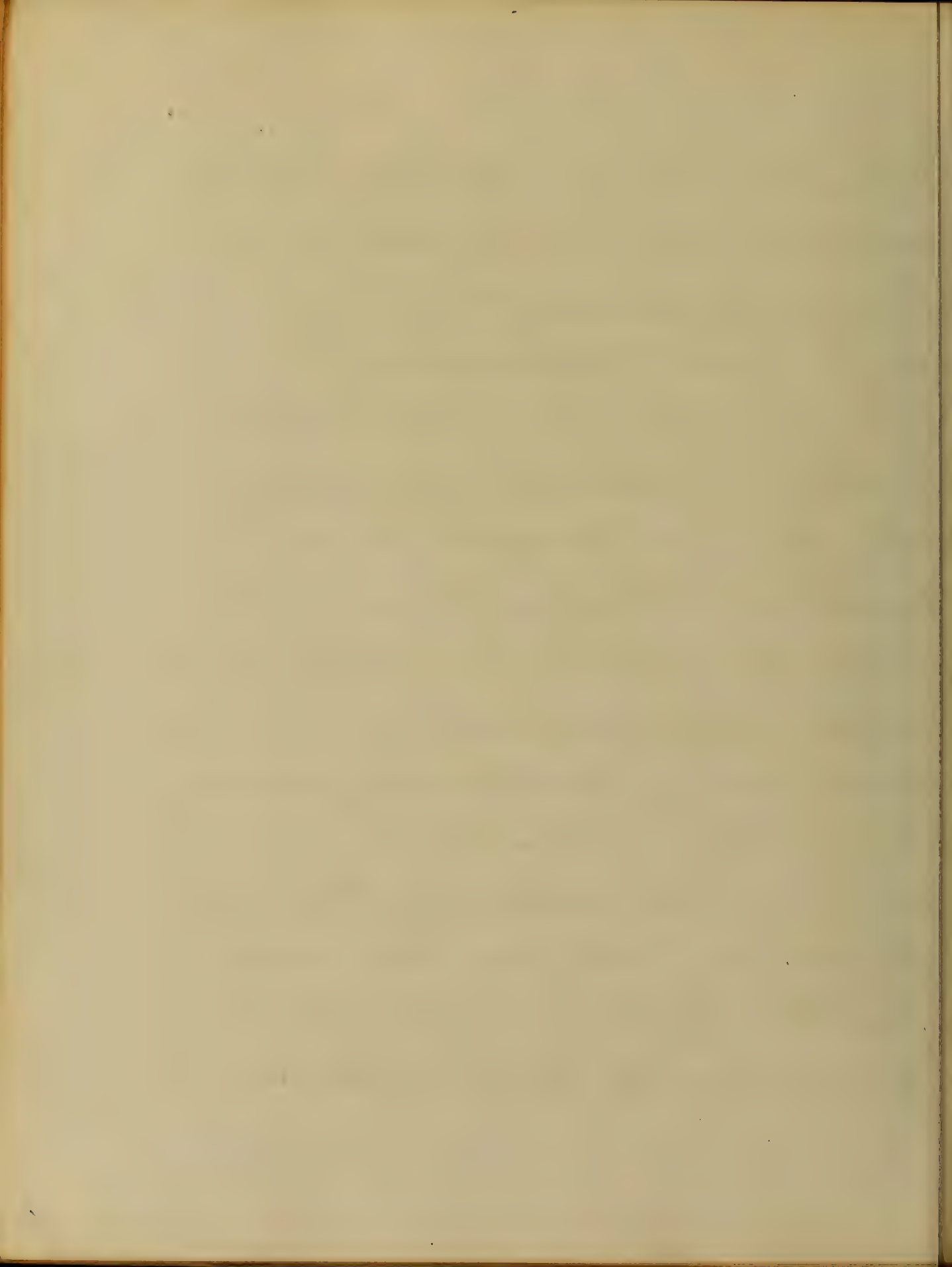


or without pleurisy, *Sp. Pneumonia*,
forms the chief disease, the double affection
is called, *Pleuro-Pneumonia*, While when
the pleurisy predominates the disease
is then called *Pneumo-pleuritis*,
Treatment, Each stage of *Pneumonia*
presents different indications for treat-
ment, measures which were once con-
sidered as abortive, are now generally
abandoned, The objects of treatment, then
in the first stage, are to diminish the
intensity of the inflammation, to relieve
symptoms, and place the system, in a
condition to tolerate the disease,
Blood-letting may be employed, to
a palliative, and to some extent, as

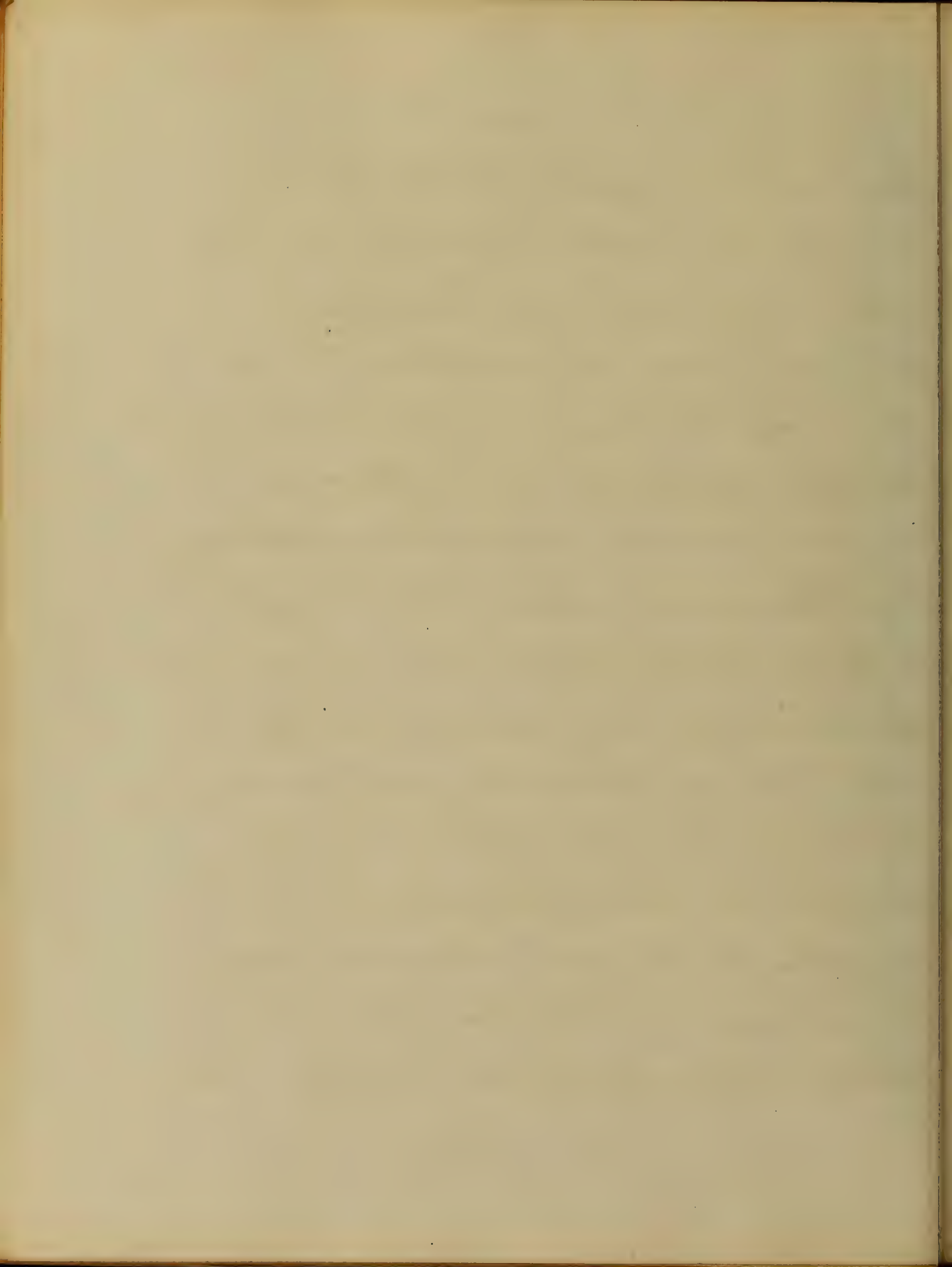


A Curative Measure, The Circumstances
which admit of its employment, Are,
high febrile Movement, the pulse more
or less resisting Compression, and a con-
dition of plethora, in at least robust
Constitution, It should not be employed,
when the febrile Movement are not
marked, when the pulse is frequent and
weak, and the patient is Anaemic
or have a feeble Constitution,

In most cases, in which bloodletting would
be admissible, provided the same ends
could not be accomplished, by other means
the latter are to be preferred, These consist
of depletion by salines purgatives, and
sedative remedies, After the operation



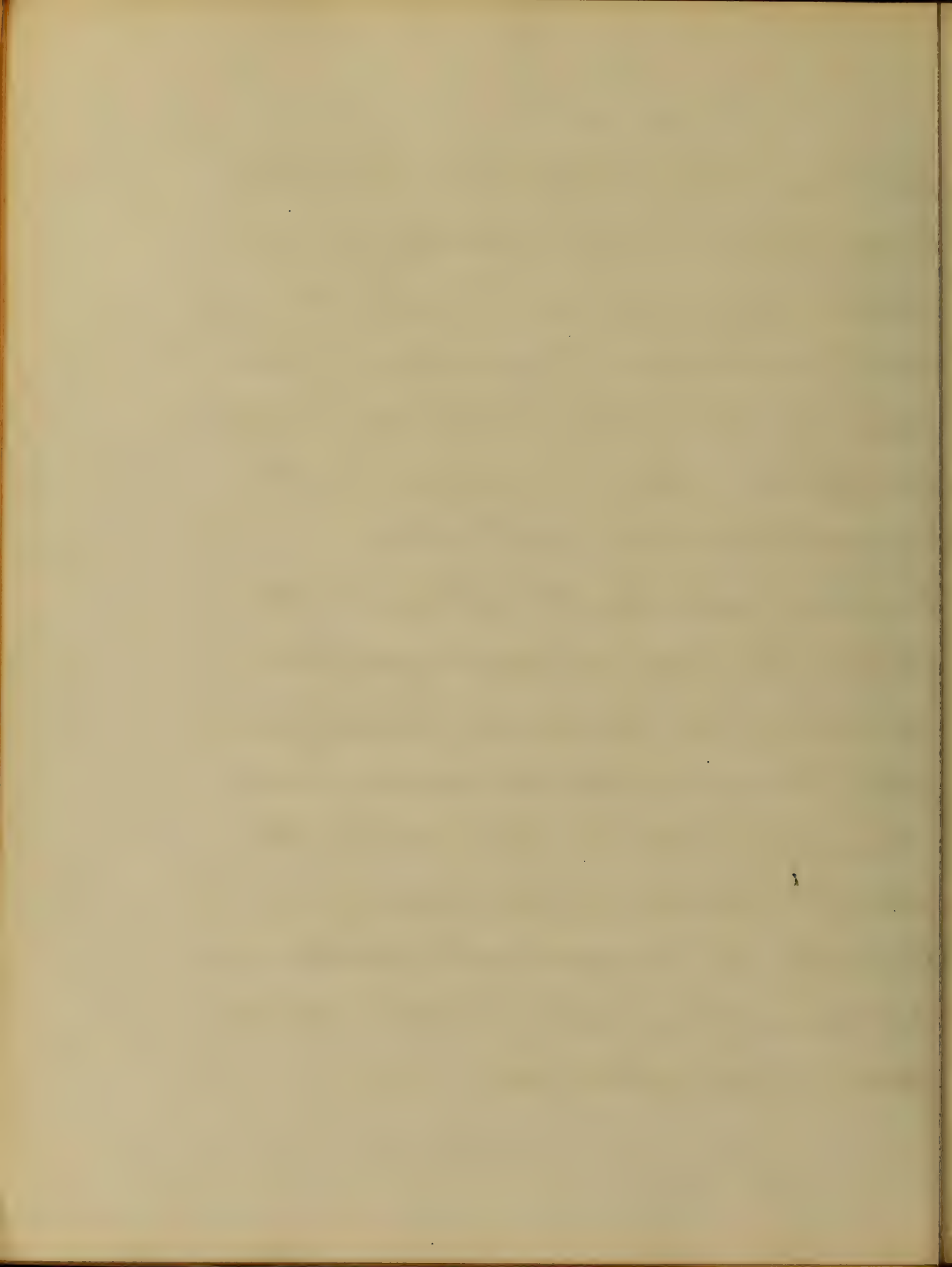
of a saline purgative, if the skin be
hot, and the pulse frequent, tartar-emetic
or some Antimonial preparation, may be
given, as a nauseant sedative, the dose
should not be large enough to produce
marked or distressing Nausea, *Veratrum*
Viride is some times used for the same pur-
pose, these remedies should not be used
if the patient's symptoms are mild, and
should not be used, when feebleness
exists, Opium should be given in the
first stage, in doses sufficient to relieve
pain, Blisters should not be used, *Stylops*,
Synapisms, or stimulating liniments, may
be employed, It is the custom in the
Baltimore Infirmary, to cover the chest with



An oiled silk jacket, This keeps the surface moist with perspiration. And a flannel covering is also used, which give all the advantages of a poultice. If pain and soreness continue, Turpentine Stupes are applied, Opium is usefull in the second stage, as well, as, the first,

It is indicated by a continuance of pain, restlessness and symptoms denoting Constitutional disturbance, An Accumulation of Mucus in the bronchial tubes, Contraindicate the use of Opium, in full doses.

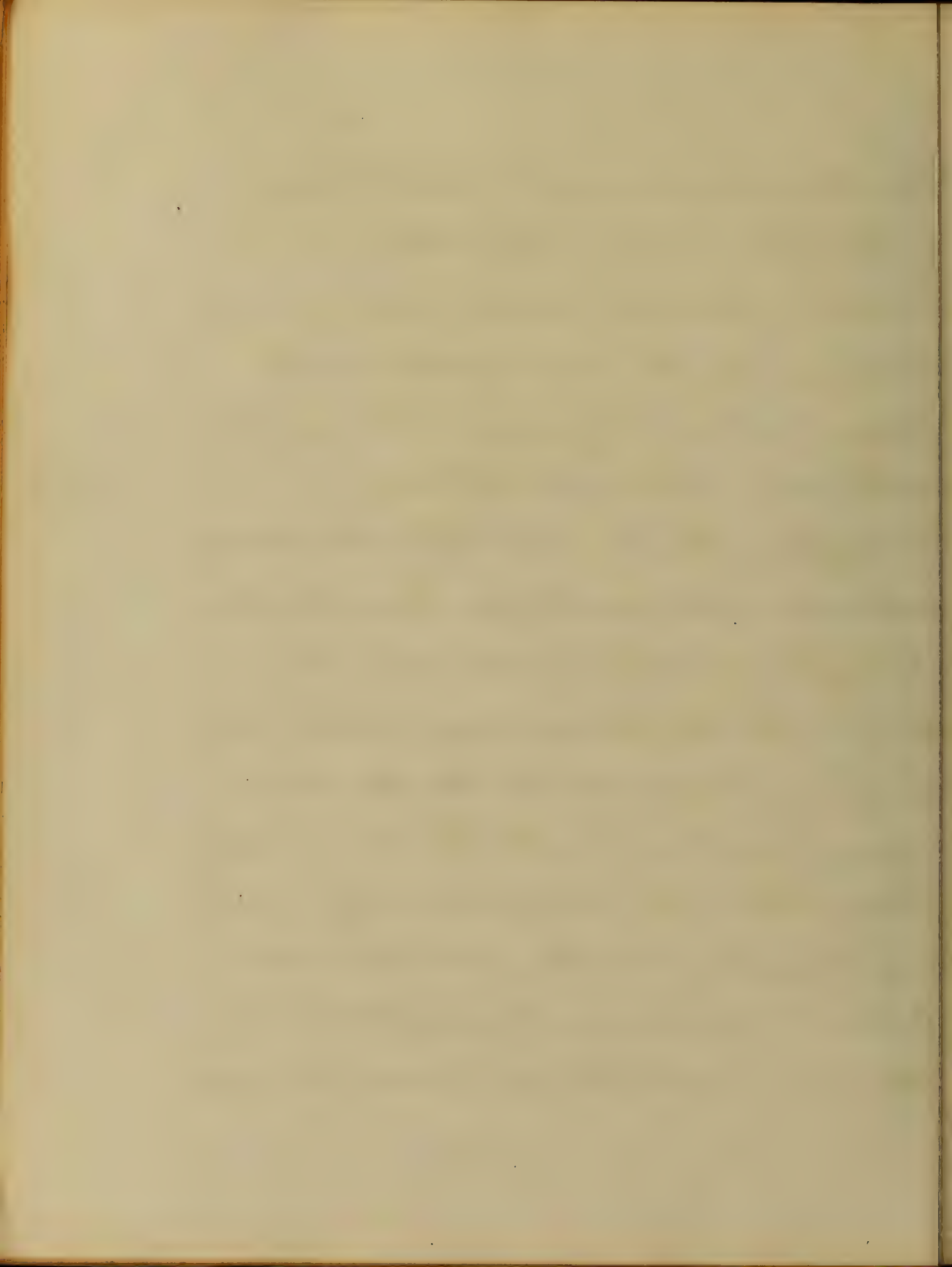
Remedies to promote expectoration, are not generally indicated, As the Stuffed matter is not expectorated,



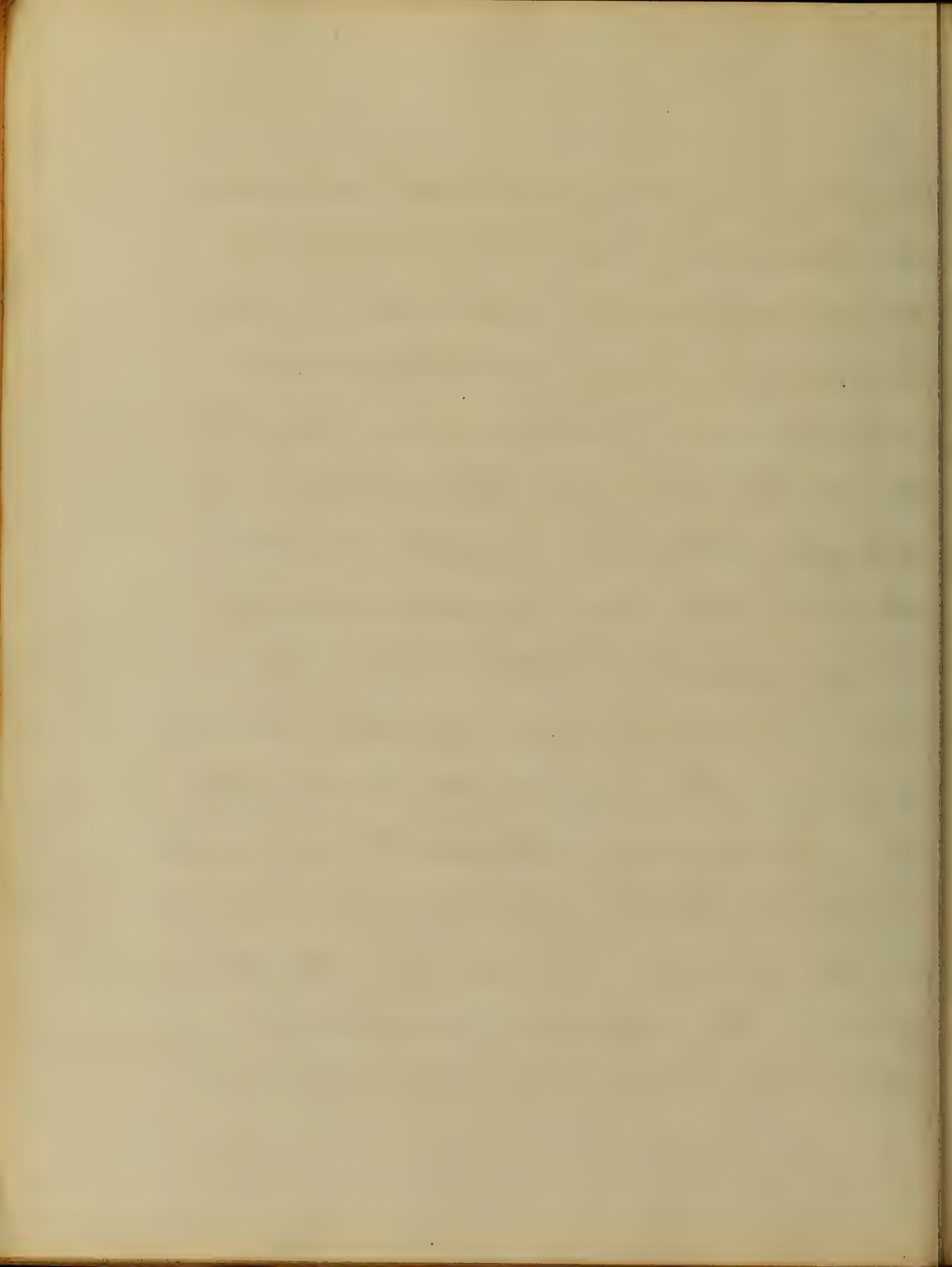
The Expectoration in the second stage
of this disease is due to bronchitis,

Sedative remedies, such as Aconite,
Veratrum Viride, may be given in this
stage, if there be high febrile movements
with out a tendency to asthenia,

To support the powers of life is the leading
indicator in the second stage, Moderate quan-
-tities of wine or brandy, some what in accor-
-dance with the patient's usual habits, may
be prescribed, as soon as there are any
signs of failing strength, than can be safely
borne, Where the crisis occurs by sweating
or by diarrhoea, Care must be taken not
to check it unnecessarily; while during
convalescence, Milk and cream, raw eggs



Animal food, and food with wine may
be allowed, with discretion, Few tonics
are more useful than Ammonia and bark
followed by Quinine and iron, with
Cod-liver oil, In some severe cases the
only question is how to keep the powers of
life up, until the foundation matter is
absorbed, Under these circumstances, brandy
is in valuable, and it should be freely
given, even to the extent of half an ounce
every two hours, in milk, or water beef
tea, for some days, Should the inflamma-
-tion end in gangrene, Stimulant and tonics
are then especially required, When the odour
of the breath is offensive, A solution of
Chlorinated Soda, or some other disinfectant



May be prescribed, The inhalation of
Spray Mediated with, Creasote or Carbolic
acid, is useful,

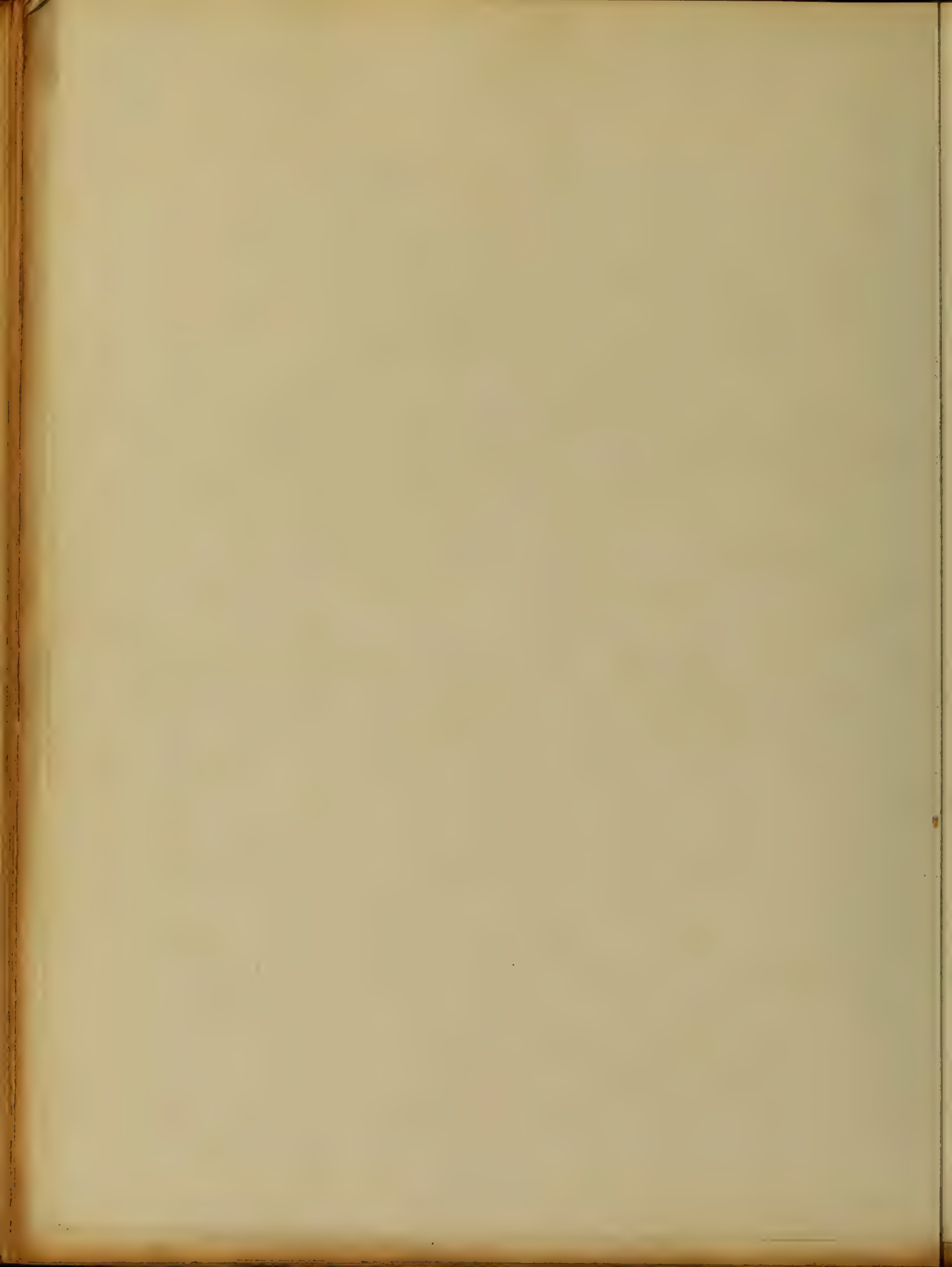
Wine and Nourishments in as large
Quantities as can be assimilated by the
weakened Digestive organs will be
required,



4
Treatise on Croup.
By
James K. H. Jacobs.
of the
University of Maryland.
Session of
1876 & 1877. —



4
Treatise on Croup.
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Croup.

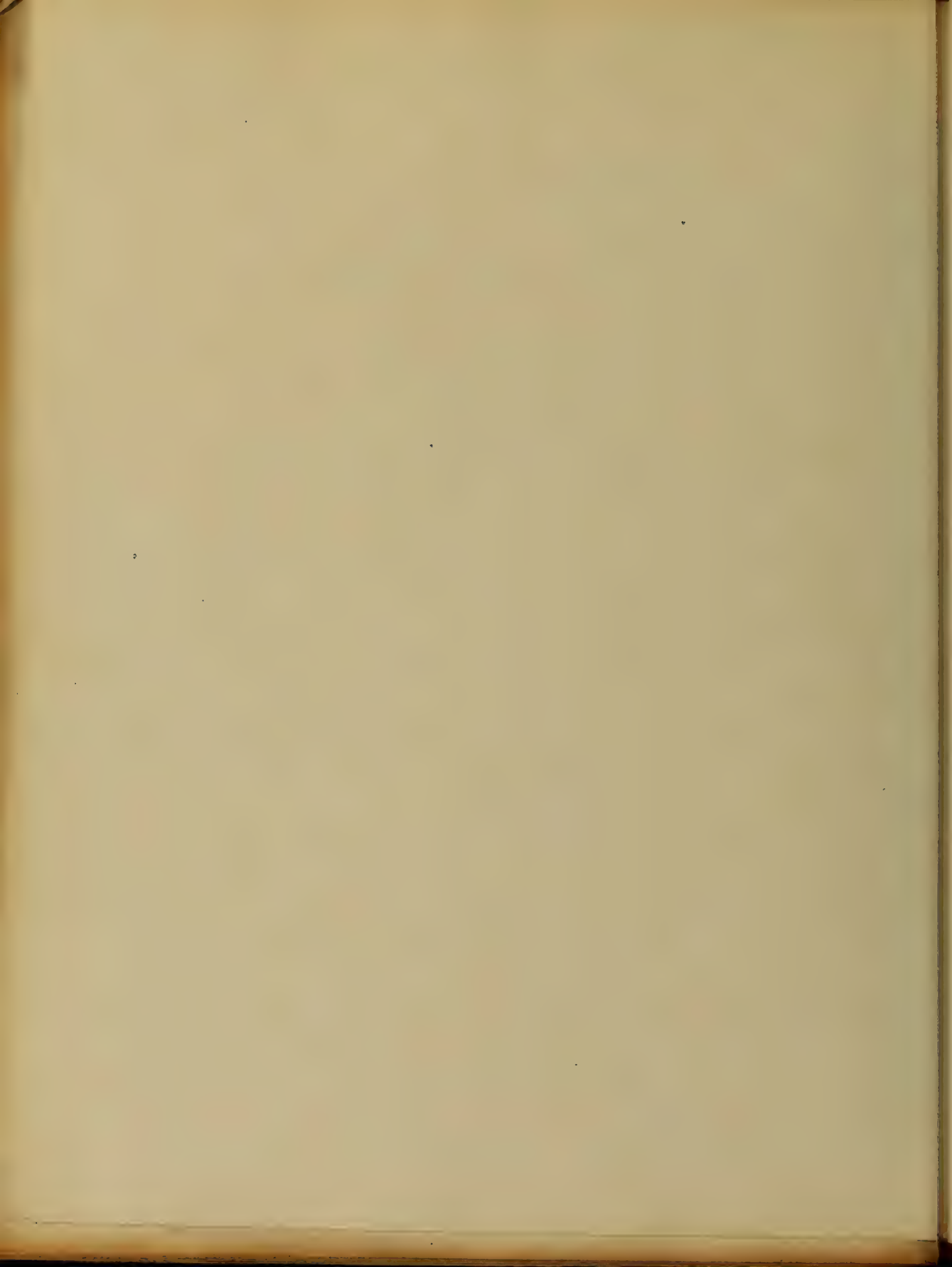
Definition

This is a word of Scottish origin, used to express that condition of the larynx in which there is inflammation accompanied by thickening of the mucous membrane and the formation of a pseudo-membrane upon it, sometimes extending as an almost continuous sheet from the larynx into the bronchial tubes, indicated by a prodromic stage, characteristic cough and hoarseness, and the expectoration of false membranes.

Etymology

Dr. Thomas Hoskins was, I believe, the first to observe and note the differential points of diagnosis between this and other disorders of the throat and chest.

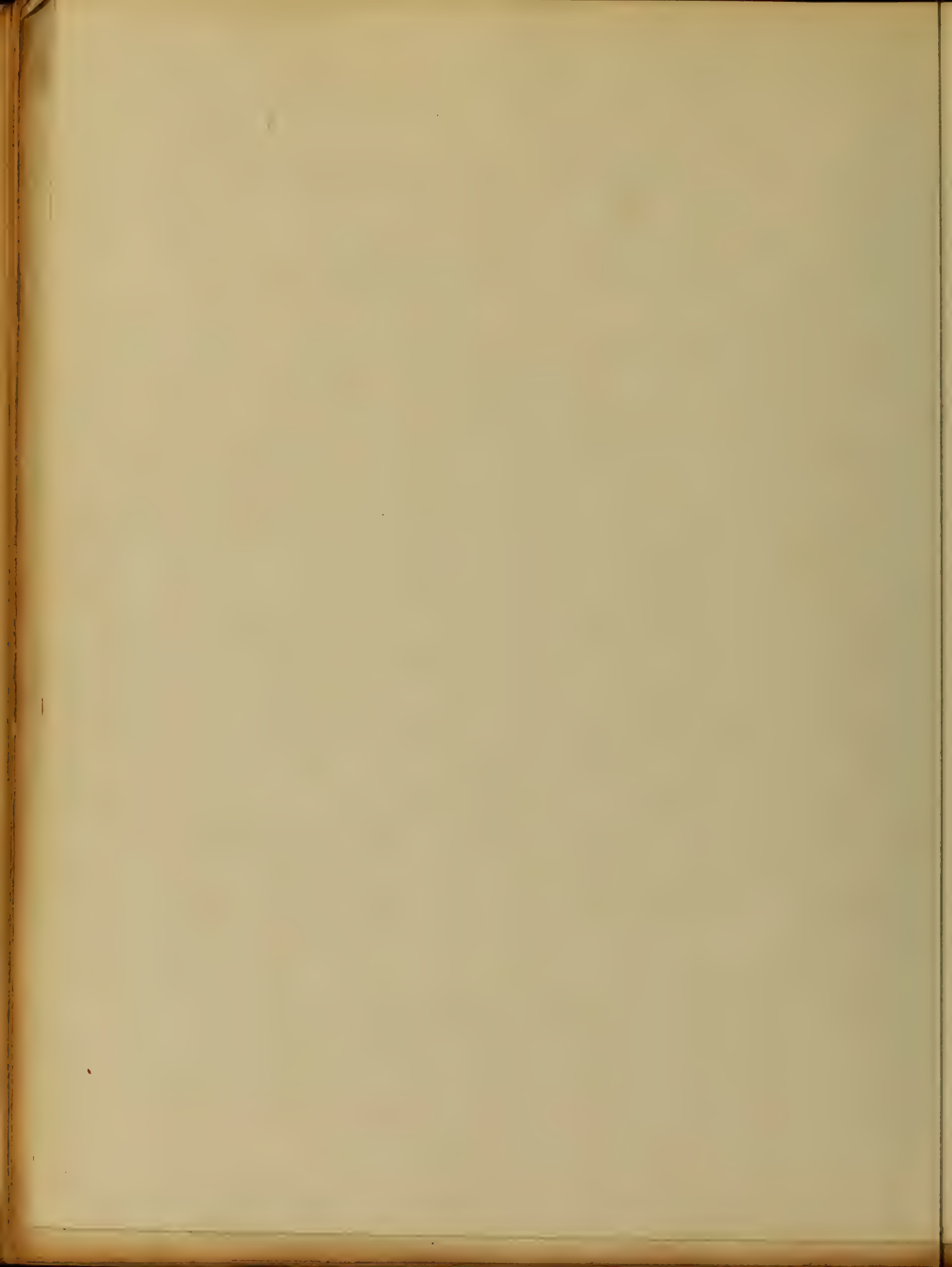
It is a disease peculiar to childhood, occurring less frequently during the period of



erupting and after the second dentition, marking the period of the greatest predisposition between the second and seventh years.

This disease is usually idiopathic, though it may supervene upon measles or complicate scarlet fever. Some children appear predisposed to it, indeed it appears to be hereditary in some families.

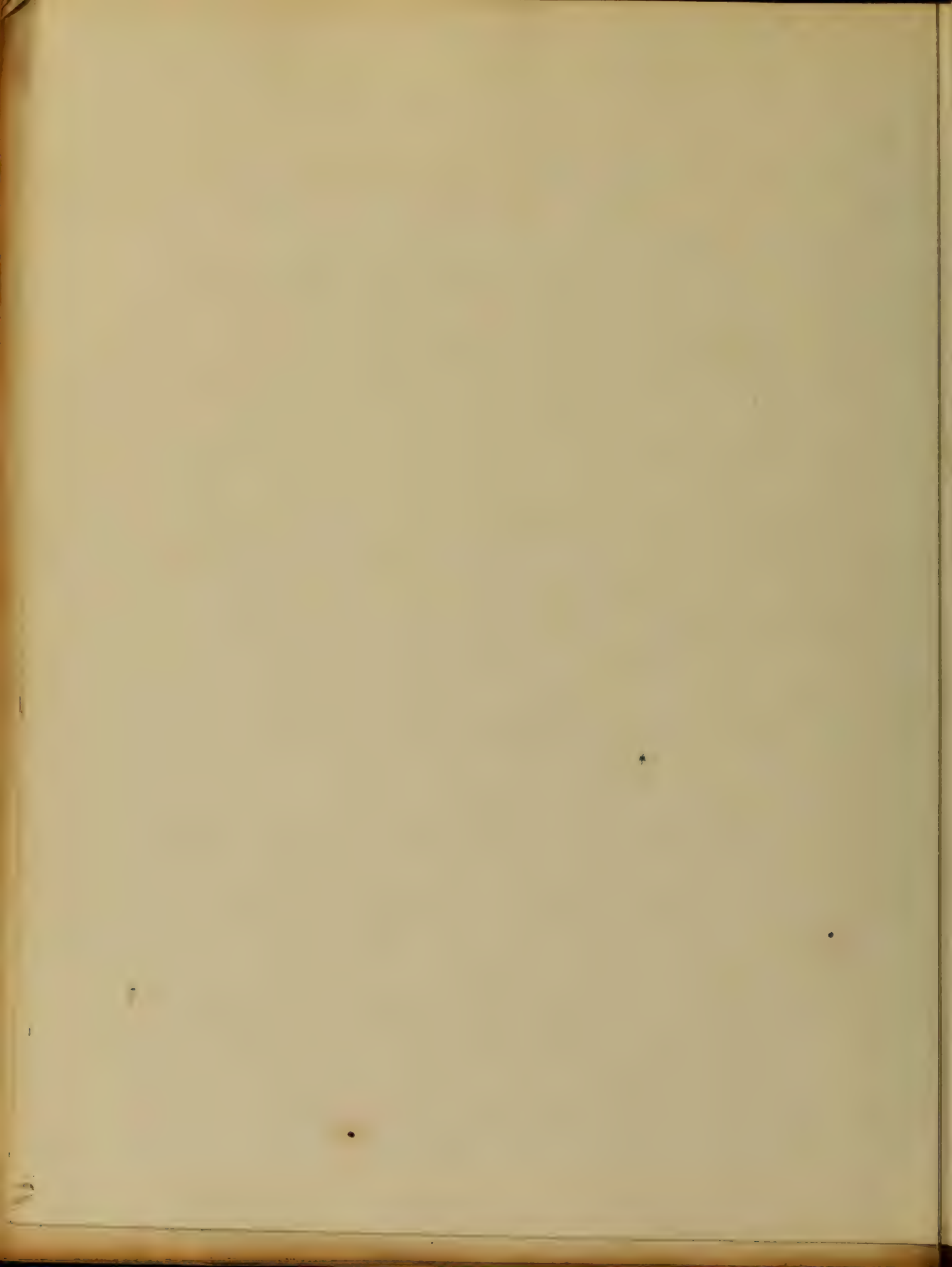
The exciting causes are sometimes hard to account for, though a North or North Easterly wind, irritating vapors, improper clothing, and a sudden change from a warm dry atmosphere into a cold raw one, appear to be the most frequent causes. It is of less frequent occurrence in maritime protected places. The most essential



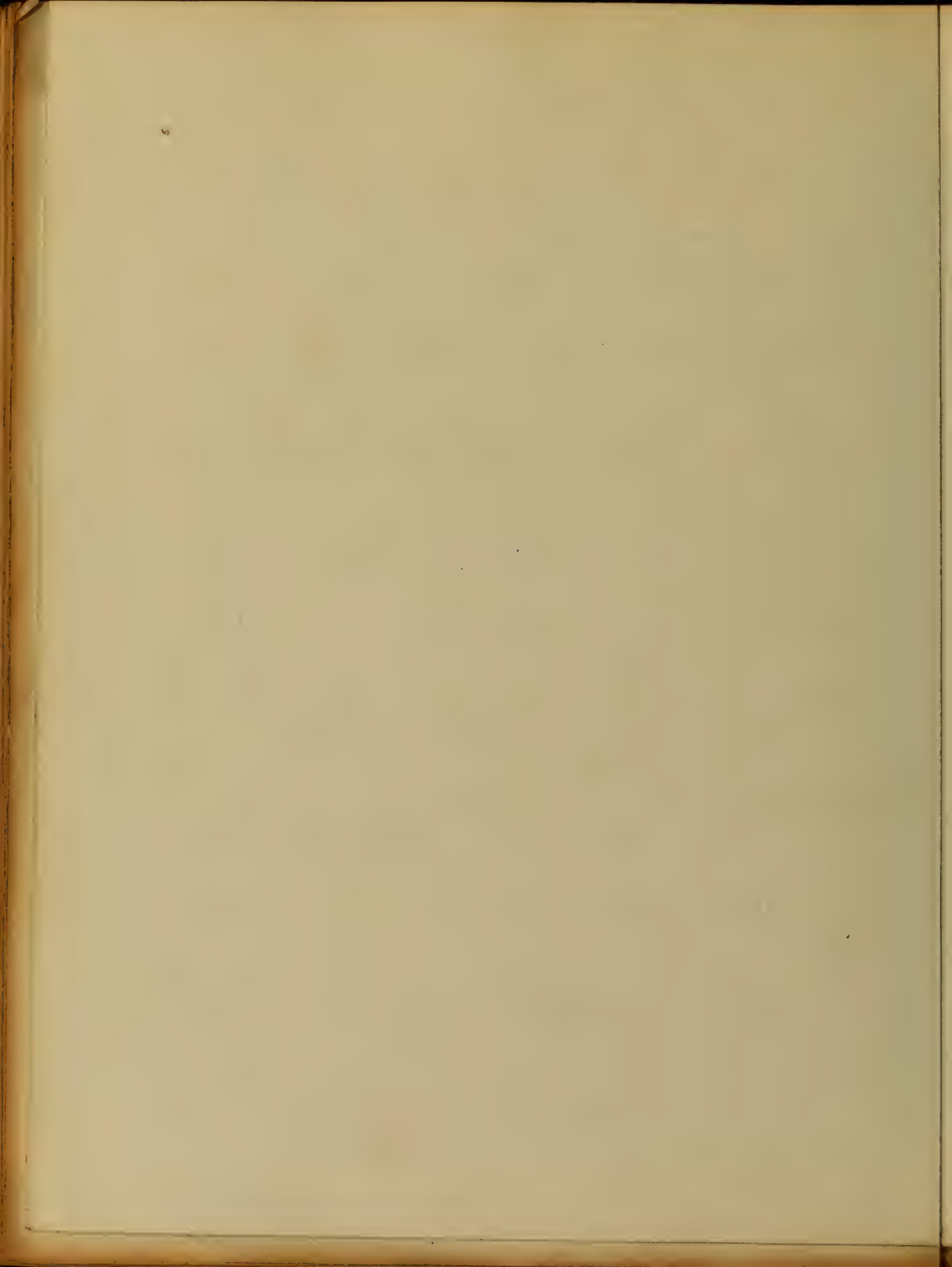
The most remarkable phenomena of
this disease is the formation of false
membrane, accounted for by Dr.
Capeland as follows: "that the
mucous membrane is itself the seat of
the inflammation of croup, and that
its vessels exude the albuminous or
characteristic discharge, which from its
plasticity, and the effects of temperature,
and the continued passage of air over
it, becomes converted into a pseudo
membrane".

atomical
of croup
The affected mucous membrane is
or less reddened, partially by ecchymosis
and partly through injection.

In some cases the inflammatory
action extends into the sub-mucous



connective tissue causing infiltration and œdema. The mucous membrane is thickened, and there is a rapid desquamation of its epithelial cells, and an abundant production of mucus. The occasional flaccidity of the mucous membrane after death, is attributed by Niemeyer to the number of elastic fibres found in its tissues. In all except the mildest cases, the inflammation extends farther than the larynx. Of 19 cases observed by Dr. Meigs of Philadelphia, in all but three the membrane extended into the pharynx. It also sometimes extends into the trachea and bronchial tubes. Occasionally there is so much



5.
thickening of the mucous membrane,
and sub-mucous infiltration - that
this alone endangers life. Microscopic-
ally the false membrane consists
(says Niemeyer) "of amorphous
or finely fibrilated fibrine, in which
numerous young cells have been
entangled during the process of its
excretion."

As a rule, the prodromata gives us
warning. In a day or two before the
attack, the child is unwell, goes drooping
about and is peevish, taking but little
interest in things which ordinarily amuse
it, is thirsty and feverish. There may or
may not be coryza, and in some cases
laryngitis is present from the first. But

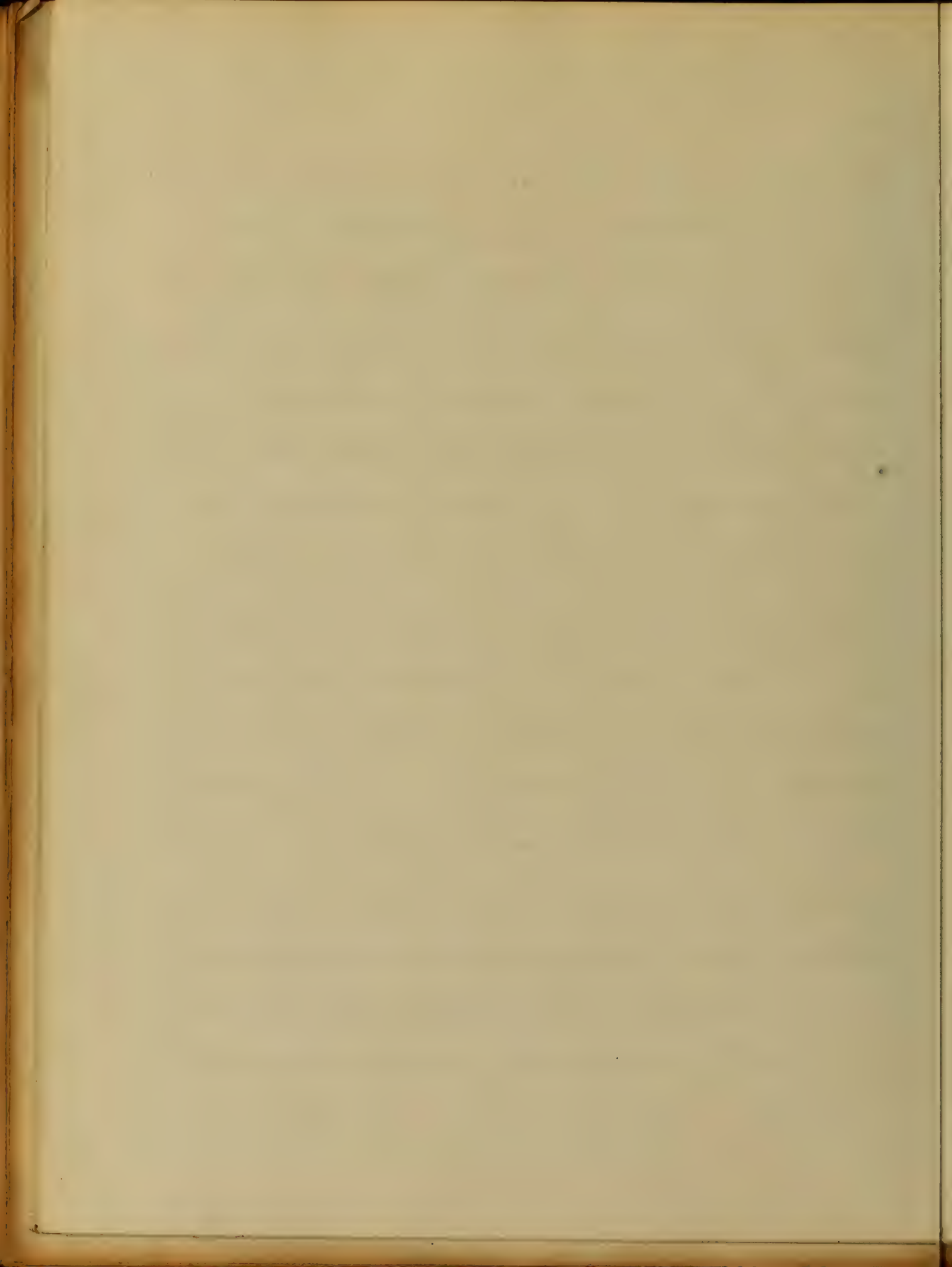
impulse
+
course



there are other symptoms which distin-
 guish this form from any other disease. Prom-
 inent among them is the cough and hoarse-
 ness. Indeed one may often diagnose the
 case before other symptoms are present,
 so characteristic are these. The cough is
 hoarse, dry and suppressed, and increases
 gradually. The above symptoms almost
 invariably precede the attack though they
 may be more or less marked. The cough
 may cease near the close of the attack but
 the hoarseness continues throughout and
 for several days after. When patches
 of membrane are seen upon the
 fauces, there is no longer any doubt of the
 character of the disease, provided we can
 put all doubt as to its being diphtheria aside.



Now this is by no means always so easy, but regarding the two as distinct diseases, it seems to me that when we know the disease to have begun in the larynx, and there are not any symptoms of rarification of air in the lungs, with expectoration of false membrane, and the characteristic cough and hoarseness of Croup, that we might, with a degree of certainty pronounce it to be croup. When the patient is to cease, the membrane is separated by the throwing out of an evacuation, beneath the false membrane. The inflammation rapidly subsides, and the patient goes on to recovery. In innumerable cases, the membrane is rapidly reproduced, and the patient becomes worse. A piece of the membrane may block up the air passage, and cause death by suffocation. When the child becomes cyanotic, and there is a sinking of the epigastrium during attempted

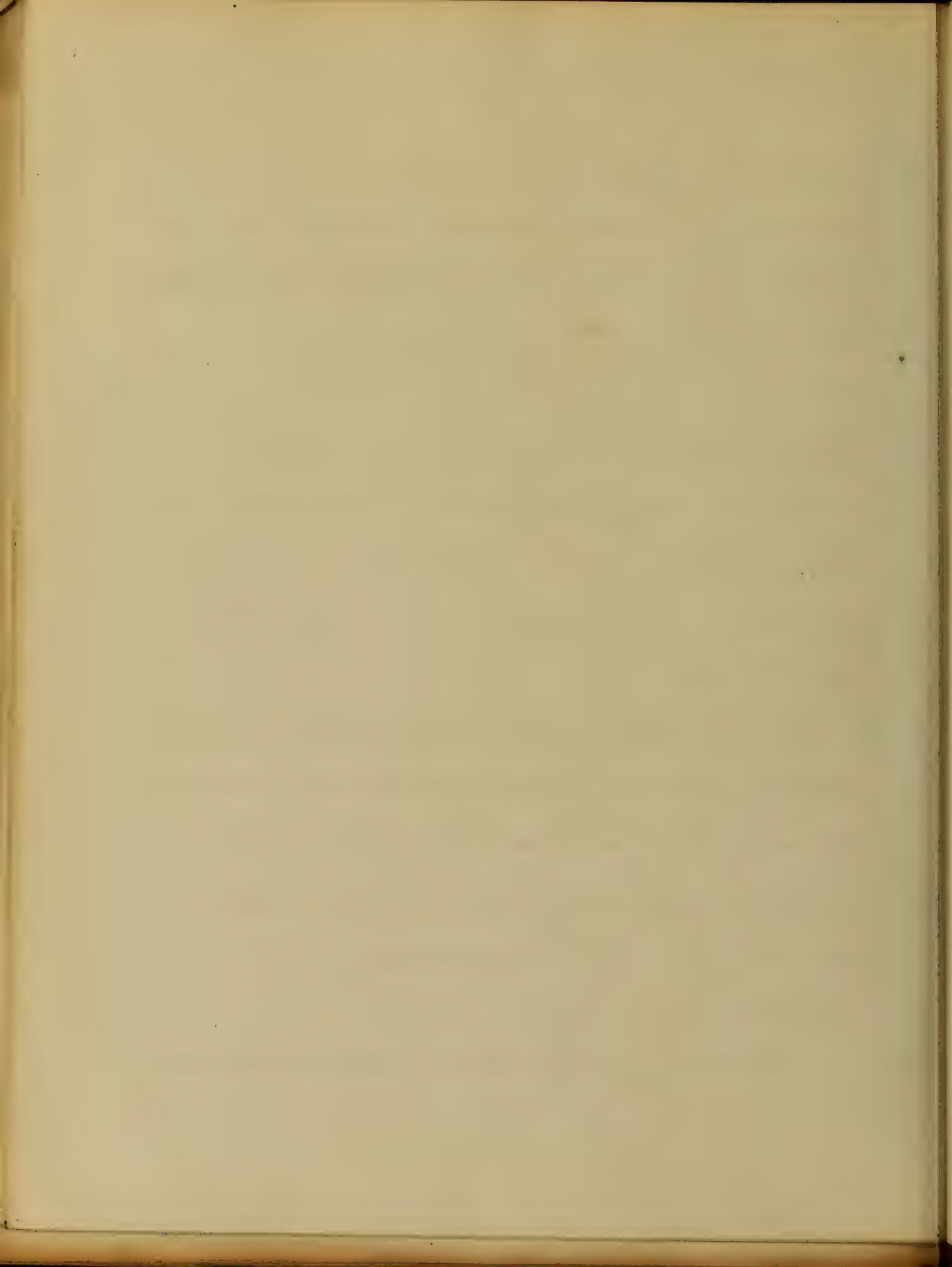


inspiration owing to suspension of air in the chest the case is a most urgent one. Indeed I have of no disease which requires more prompt measures from the first, than croup. In primary croup the pulse at the commencement raises to 110 - 120 per minute. In the course of the disease it becomes more frequent, and toward the close of life is feeble. In some cases there is every reason to believe the patient is recovering when a relapse or recession occurs he is suffocated by detained mucus.

Indeed, the appearance of a child in croup is most pitiable, it throws itself about, clutches at its throat, and insists upon being moved from one place to another, is restless and frightened, and in short presents all the symptoms of one who is suffocating.

Stenosis

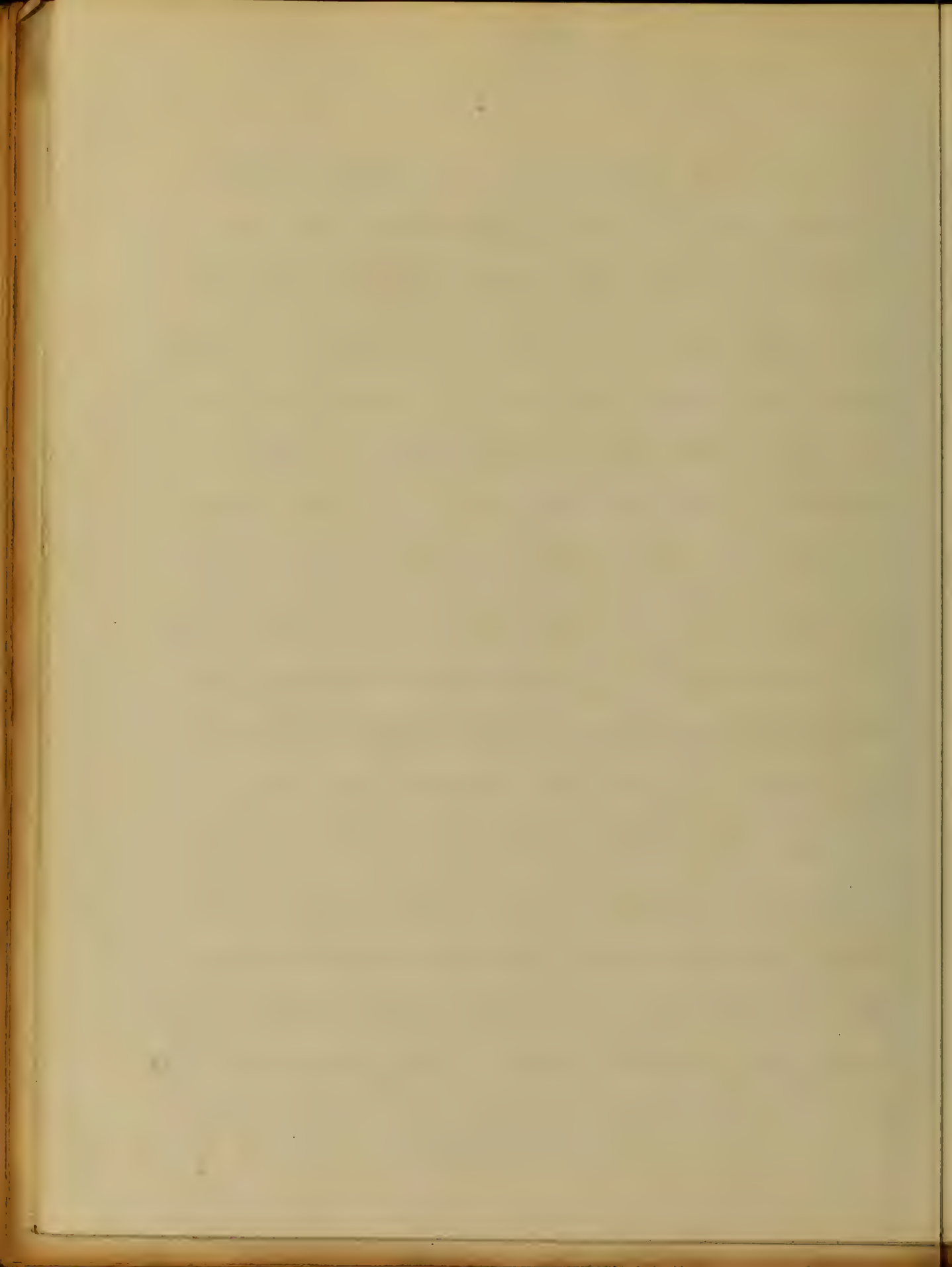
In speaking of the symptoms of croup, I spoke of



those peculiar to true croup, and shall now only mention those points of differential diagnosis between this and other forms, and therefore distinguish it from diphtheria, which in difficult cases may enable us to compare the character of the disease. Now the first thing says Prof.

Howard, "When you are called on to see a child with croup, ask if it ever had it before, and if it has, it is almost sure not to be true croup."

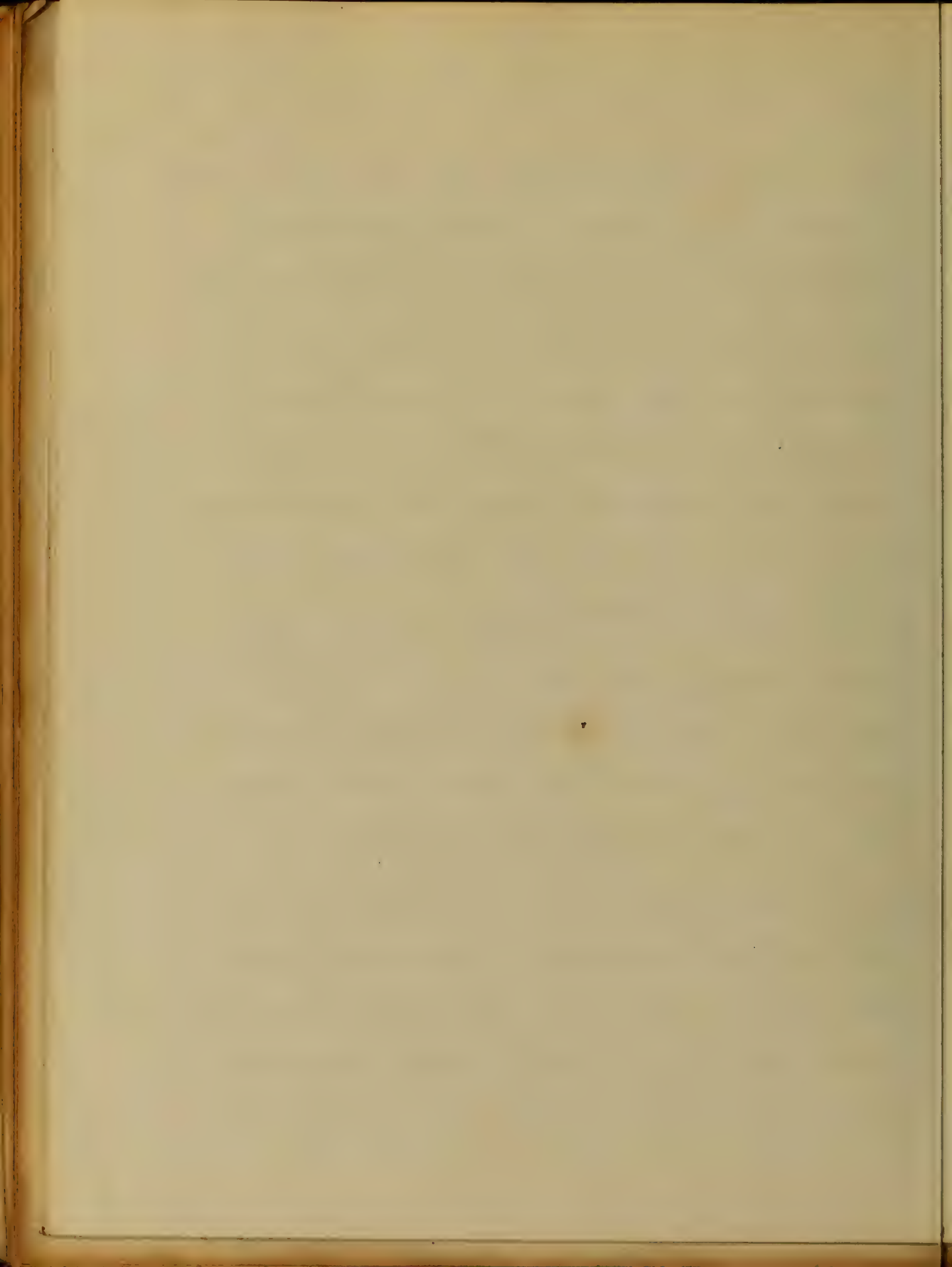
It is most likely to be confounded with spasmodic laryngitis; but while true croup begins with symptoms at first slight, progresses slowly, but with that terrible steepness which sets all our efforts to check it at defiance false croup, though it may be preceded by coryza begins abruptly, and at night, between 10 & 12 O'Clock. The symptoms of false croup have their maximum intensity from the first, the coryza is loud and sonorous, while in true croup it is hoarse.



and rough false membrane. The voice in false croup is natural, or nearly so between the paroxysms, while in true croup it is husky and rough throughout. As a rule, there may also be some patches of false membrane in true croup. For the points of distinction from diphtheria ~~see~~ refer to what I said above. This disease should not be confounded with *Laryngismus stridulus*, or with paralysis of muscles of the glottis. Again, while the malignancy of true croup is frightful, false croup is seldom fatal. Prof. Howard said in his lectures of 1875 that he had never seen a case of death from false croup alone.

Prognosis

There remains but little to be said of the likely termination. In children of seven years of age or over, the prognosis is better than when younger, even when we have every reason to believe that we may



will take place we must be very cautious in giving an opinion, as this is a most treacherous disease. when there is great dyspnoea, stimulus expiration as well as inspiration, pulse of surface, pulse more and more frequent and weaker, the prognosis is very bad, while if the membrane is thrown off, symptoms abate, and suppuration begins to form, the prognosis is more favorable.

degrees of inflammation

As to this, I do not know that I can do better than quote Aitken, He says "opinions are very much divided as to the nature of the epidemic influenza, and whether or not the disease is contagious or infectious"

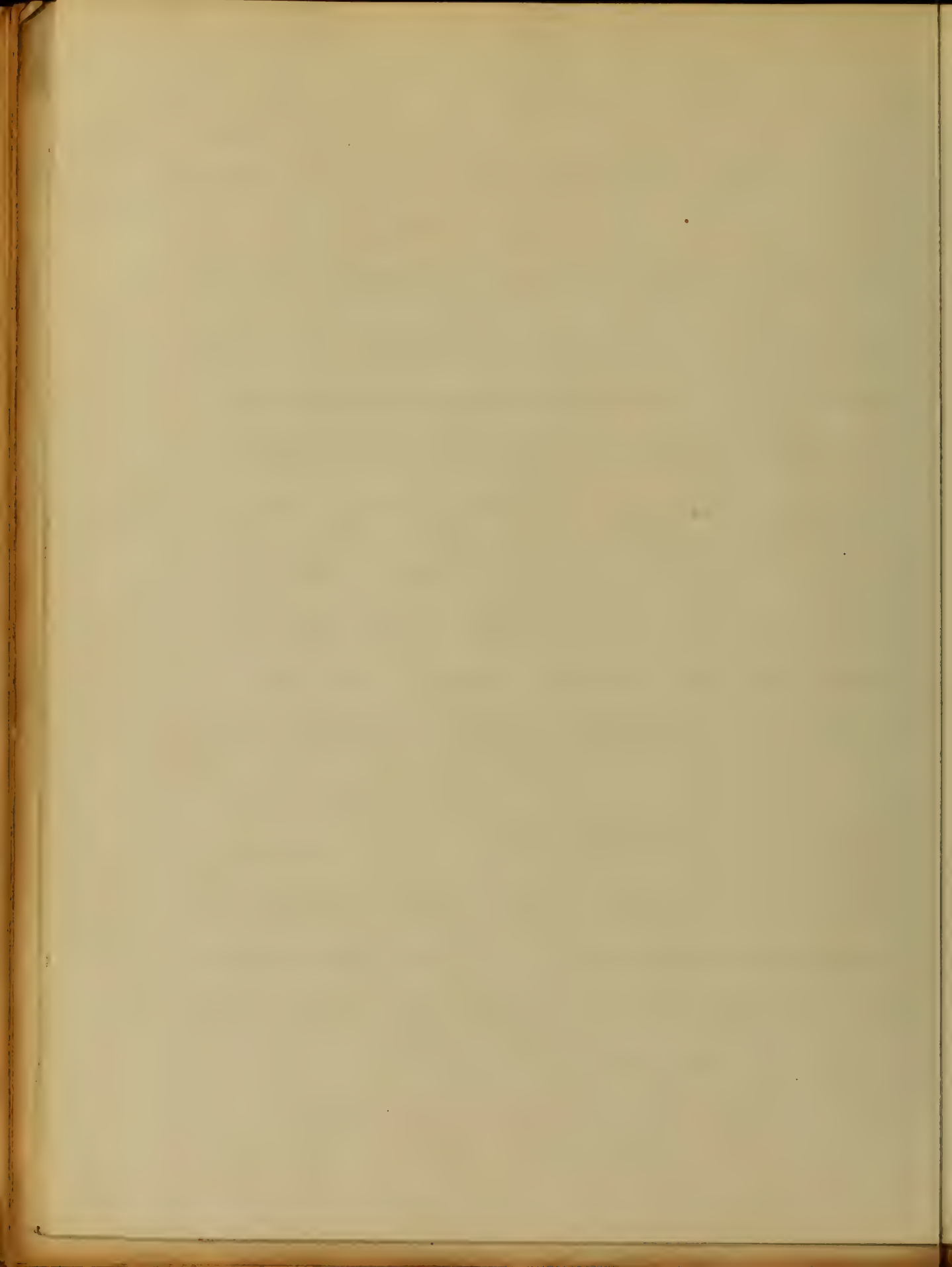
hygiene

In no disease probably does that most important branch of medicine, Hygiene, accomplish more than in the prevention of Croup. The child should take daily exercise in open air, when it is at all fit.



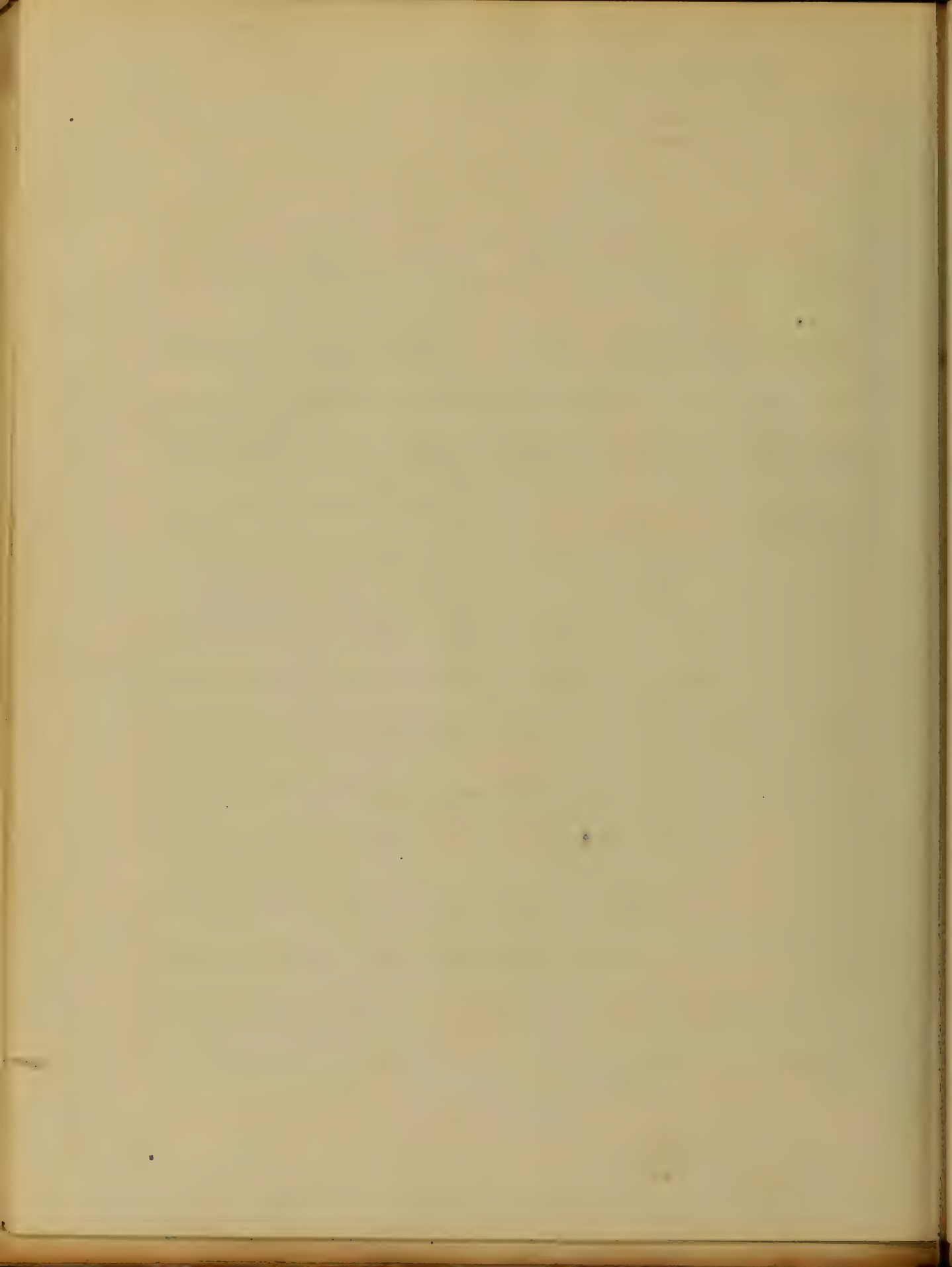
but must be kept in during a north or north east wind, and in damp raw weather. Frequent bathing of neck and throat in cold water, but it must be wiped very dry and flannel always worn, (as indeed should always be done by children, and even grown persons,) avoid hot dry, and otherwise irritating atmosphere.

A vessel of water should always be kept upon the stove or beneath the register, in such a manner that the heat will pass over it, and above all things, the child should not be raised like a hot house plant, nor should it be foolishly exposed, as the ladies are sometimes disposed to do, with the idea of lessening its susceptibility to cold. But the nursery must be well ventilated at all seasons, and if possible, have an open wood fire.



Emetics

There are so many remedies proposed, and some so directly contrary that I cannot but be struck with the force of Prof. Howard's remark, that whenever you see so many medicines recommended as being of especial value in a disease, you may be sure that they are none specifics. It is, all while waiting for the physician, to give the child hot drink, wrap him up warm, and apply hot wet sponges to the throat. It may be well, in early stages of disease, if it is primary, to give a depressing emetic, but this is seldom called for. Ipecacuanha may sometimes be given, though Sulphate of Copper is by far the best emetic we can use. Sulphate of Copper one or two grs, and repeated in ten minutes, if Emesis is not produced, or smaller doses repeated oftener, is sometimes used with good effect. Emetics are only called for when

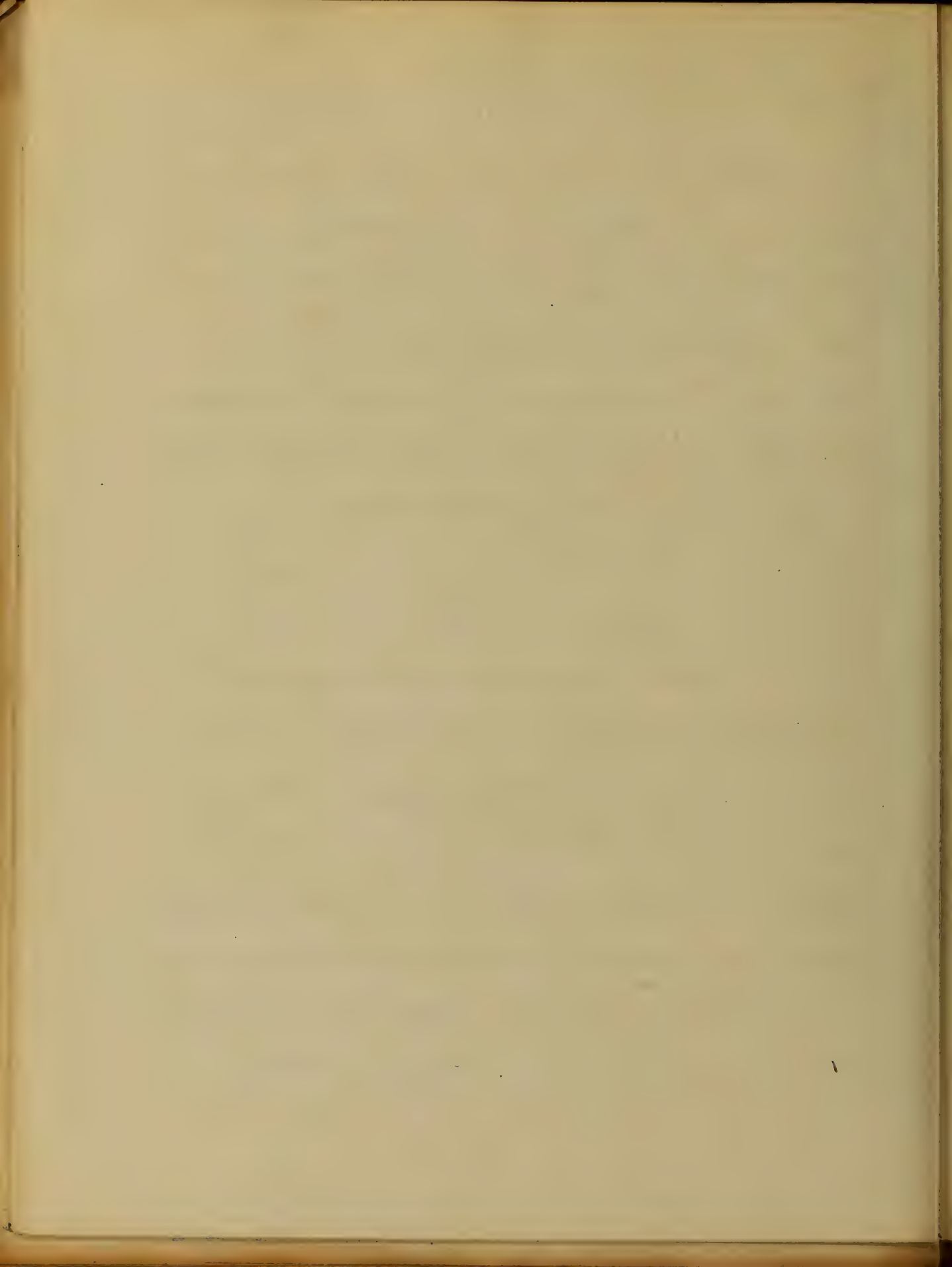


obstructing membrane black up the air passages, and the child cannot cough it up. We should be very careful to give the Sulph. Cop. in doses large enough to produce emesis, and discontinue it when not needed and when no vomiting follows its use, and when there is a passage of it through the bowels.

R. Sulph. Cop. ^{gr} X — XV.

Aqua ζ ii

M. S. Give a large tea spoonful every 5 minutes until vomiting sets in. The atomizer of Codman and Saurtuff is invaluable in the treatment of croup. A full and steady stream of vapor is kept up by means of a spirit lamp without any suction, and Leavelle with say, he uses the lime water of the shops for its supposed solvent effects upon the membrane. The temperature



of the room should be 75° or 80° with a dry towel
 and cover. The inhalation of steam sometimes appears
 to be followed by especial benefit, and in ordinary cases
 cold applied over the larynx is followed by great
 good. I Lewis Smith, in his work of 1876, prefers
 cold, to warm poultices or other warm applications.
 The best way of applying it, he says, is to take a piece
 of salt pork, dust some Camphor upon it to make
 it more irritating and apply this to the front of
 the neck, and over this place a bladder of ice.

Bleeding should never be practised in true
 croup. In the early stages Curdial sedatives
 may sometimes be called for in robust children.
 It is sometimes well to administer a Clyster (to give
 the diaphragm room to act, by evacuating the
 bowels) A good one is three (3) parts water and one
 (1) of vinegar given cold.



While Nimmeyer and Lewis Smith both think it very doubtful whether or not Catuonal has any effect upon false membranes, both strongly advise its use in small repeated doses. Prof. Bennett also uses it ^{and} with benefit. It is important however to bear in mind the remarks of Prof. Chew. He says, because Catuonal does not salivate children so readily, it is the more necessary that we be careful in its employment, for by its tardiness to produce salivation we lose an important guide for stopping its use, for though it may not salivate so readily, it acts upon the system as rapidly as in adult life.

Would not quinine in early stages be of advantage by paralyzing the white corpuscles, stopping their amoeboid movements,



and preventing effusions? It is also an
anti-pyretic and a tonic. Iodide of potassium
might also be of advantage owing to its con-
stitutional effects and absorbent powers.

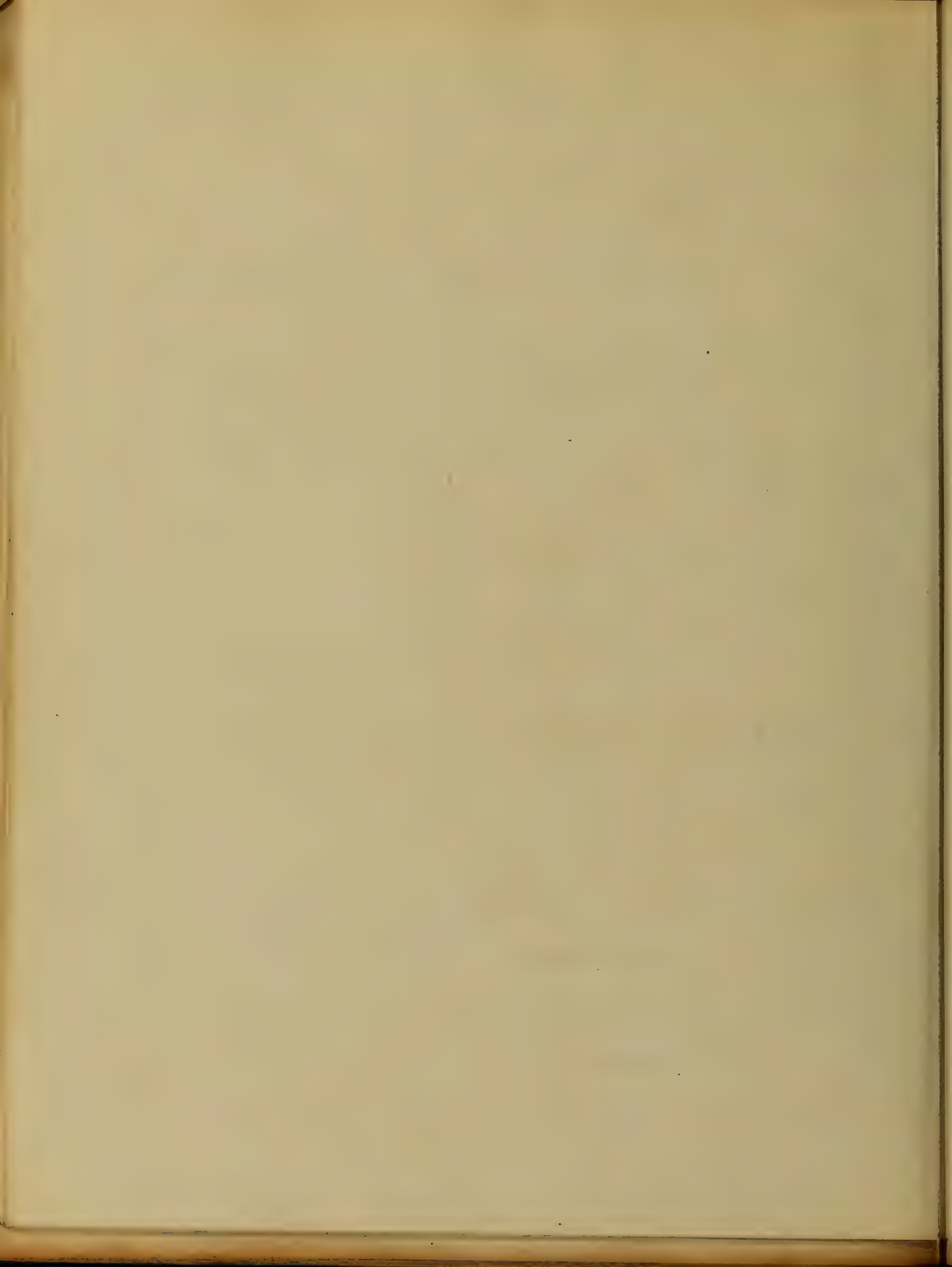
Chlorate of Potash has a good effect.

The following is an excellent prescription:

R Potas. Chlorat.	ʒi
Ammon. Muriat.	ʒii
Syr. Simplic.	ʒi
Aq.	ʒii

℞. S. Give one to two teaspoonfuls every
half hour or hourly to a child from 3 to 5
years old.

The following is Dr Lewis Smith's favorite
prescription, for which he claims very great
merit. It will be found in his work of the
year 1876, ~~and~~ with the formula in his



located on Group, page 492.

R_x Acidi Carbolic. gtt V-X
 Liq. ferri Subsulphat ℥ii
 Glycerin. ℥i

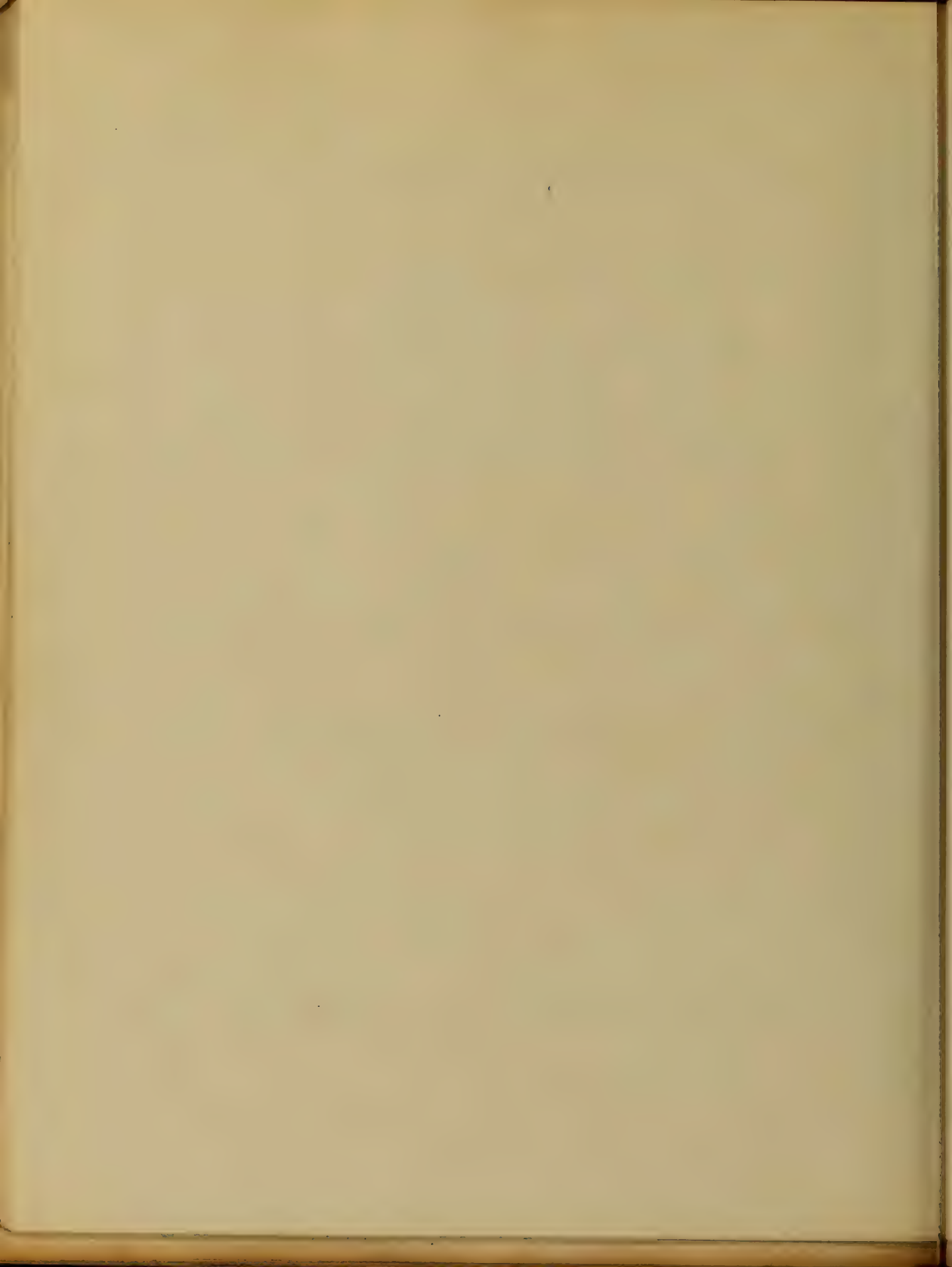
M. S. To be applied from 3 to 6 hours.
 also the following:

R_x Brominii. ℥i
 Potas. Bromid gr. X.X.X.

M. S. 20 to 40 drops to ℥ij ℥i and apply
 locally.

Beside the above remedies there are numerous others, all of which possess more or less virtue, and when one fails we can try another.

Tracheotomy appears to be steadily gaining ground. This is probably owing to the fact that it is now more promptly performed than formerly.



and not deferred as formerly, until the air
in the lung has become rarified,
producing a condition in the chest similar
to that caused upon the skin by a dry
cup, nor until the patient has been roused
by emetics and the like, or poisoned by
carbonic acid. The responsibility attending
tracheotomy should be borne in mind
and the reproaches which might
follow if death should ensue.

There is no doubt however, that there are
many cases in which this is the only
~~remedy~~ effectual remedy, and when the
physician has decided upon its use, he
must act with promptness and energy.
A good surgeon might, in an urgent
case, perform the operation with a

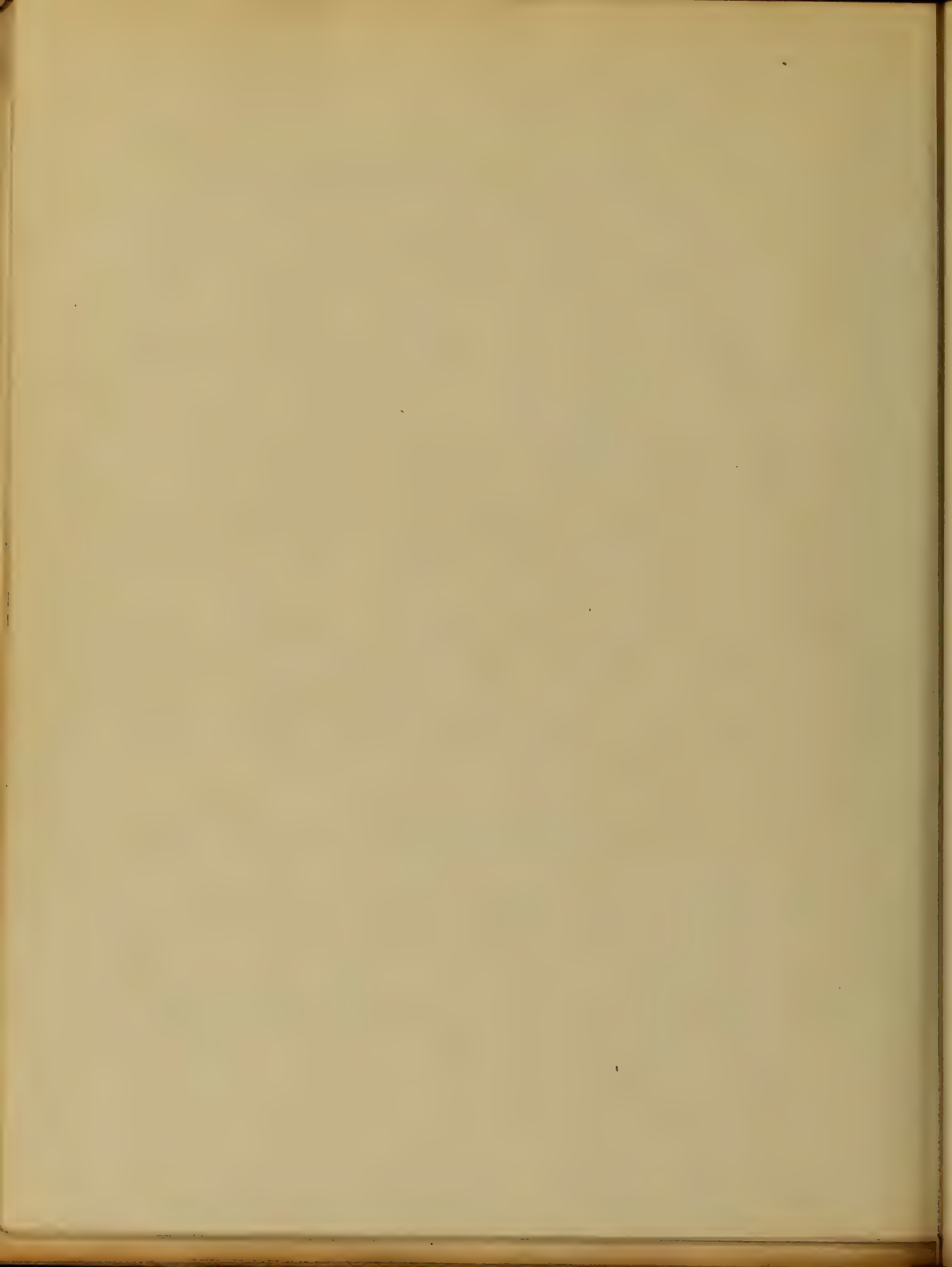


21
pocket knife and quill, but great care
is required to avoid cutting the vessels.

After the operation, appropriate
means should be adopted to secure
the proper passage of air, for by admitting
it too cold, it would reach the bron-
chial tubes in a condition to produce
catarrh or other trouble.

Give good nutritious food that is easily
digested, watch the state of the patient's
health, and combat such symptoms as
may arise.

To perform Tracheotomy successfully, requires
a thorough knowledge of the anatomical
relations of the part, and for this in-
formation, and the mode of operating,
I refer the reader to suitable works.



The one last point that I shall mention
can never be too highly appreciated,
and that is the value of time.

If the child begins to fail, no restorative
means should be spared, every mo-
ment life is prolonged is of ines-
timable value, the membrane pos-
sibly undergoing that change which
tends to end in its ejection.

